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CREDIT CARD PRE AUTHORIZATION FORM

I authorize Dr. Dina Trevino, Ph D to keep my signature on file to charge fees, or partial fees, to my credit card account for services to _____ for the balance of charges not to exceed the amount of the full fee as detailed in the "Agreement for Psychological Services" for each appointment including any fees for missed appointments or cancellations without 24 hours notice.

I agree that:

- If insurance/employee health benefits are assigned to Dr. Dina Trevino, I am still responsible for the total charges incurred regardless of any insurance partial payments unless other arrangements regarding fees have been made. This responsibility will be limited by any participating provider arrangements Dr. Trevino may have with insurance company or network.
- This authorization is valid until canceled in writing.
- Charges for ongoing services will be posted to my credit card account within a week of each service date. The amount charged to my account will depend on use of services, insurance arrangements, and agreement now in effect with Dr. Trevino. You will be provided with a receipt for each charge made.
- If I have any questions or concerns regarding charges applied to my account, I will contact Dr. Trevino's office immediately for further assistance. *I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. Trevino.*

Cardholder Name: (Please Print) _____

Address where statements are mailed: _____

City: _____ State: _____ Zip: _____

Card Type: _____ Account # _____

Expiration Date: _____ Security Code: _____

Cardholder Signature: _____ Date: _____