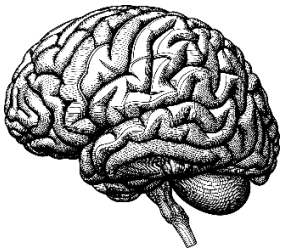

GKB Neuropsychology

1560 Wall St., Suite 304, Naperville, IL. 60563
Phone: (630) 379 – 3457
Fax: (630) 708 – 7445
Email: info@gkbneuropsychology.com

Credit Card Authorization Form

This form authorizes George K. Bialkowski, Psy.D., PLLC, doing business as GKB Neuropsychology ("the Practice") to securely process credit or debit card payments for professional services. All transactions comply with PCI DSS payment-security standards and HIPAA confidentiality requirements. No full card number or CVV is stored electronically.

Patient Name: _____ **DOB:** _____

Authorized Uses *(check all that apply)*:

- ☐ Copayments, coinsurance, or deductible amounts due at the time of service
- ☐ Balances remaining after insurance has processed claims
- ☐ Self-pay evaluations, deposits, or retainer fees
- ☐ Missed appointments or late cancellations, in accordance with the Financial Responsibility Policy
- ☐ Administrative/non-clinical services requested by the patient (e.g., copies of records, reports, or letters)
- ☐ Other *(specify)*: _____

Cardholder Information

Cardholder Name: _____ **Phone:** _____

Billing Address: _____

Card Type: ☐ Visa ☐ MC ☐ Discover **Last 4 Digits:** _____ **Exp:** _____ **CVV:** _____

I authorize the Practice to charge this card for fees owed for services provided to the above-named patient. I understand and agree that:

- The Practice will provide reasonable notice of any charge prior to processing unless the payment is made in person at the time of service.
- Charges may include copays, deductibles, or balances not paid by insurance, consistent with the signed Financial Responsibility Policy.
- I may revoke this authorization in writing at any time, except for charges already processed.
- The Practice maintains secure, limited-access handling of card data and will notify me before processing any charge.
- Any disputes regarding charges will be resolved according to applicable card-network rules and the laws of the State of Illinois.
- This authorization expires 12 months from the date below or upon written revocation or termination of services.

Cardholder Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

Patient Signature *(if different)*: _____ **Date:** _____