Financial Agreement

This form authorizes, Alicia Salzer MD, 160 Broadway, Suite900 East , New York, NY 10038 to bill my credit card for self pay client's office visits.

For insurance clients: Dr. Salzer will utilize this credit card for all patient responsibilities should the insurance indicate that all or a portion of your session is the patient responsibility due to deductible or co-insurance. (Co-Pays are payable in cash at the time of service).

It is understood that, in keeping with the cancellation policy of this practice, this credit card will also be used to charge for missed appointments that have not been canceled 7 days prior to a scheduled session or in the event of non-payment of a bill or past due balances.

Patient's Name:
Name on Credit Card:
Credit Card (Amex, MasterCard or Visa):
Card Number:
Expiration Date:
CVV Number (3 or 4 digits):
Zip Code Associated With The Card
Signature:
Date: