Sid Binks, PhD, ABPP-CN

Neuropsychologist/Clinical Psychologist

Neuropsychological Assessment
Psychoeducation Assessment
Forensic Assessment

SidBinks@aol.com
www.lgbtc.com/sid

Individual/Couples Psychotherapy
Multi-Cultural Identity
HIV Issues

202 255-5187 (P) 3000 Connecticut Avenue, NW Suite 238 Washington, DC 20008 (F) 877 684-8823

CREDIT CARD PAYMENT AUTHORIZATION FORM

Date:_____

Name as it appears on Credit Card:_____

Check One: ☐ Visa ☐ MasterCard **CVV Code:**_____

Account #_____ **Exp Date:**_____

Billing Address:_____ **Zip Code:**_____

Please check below:

☐ I authorized Dr. Binks to charge current and future rendered services to the above account on a monthly basis.

☐ I authorize Dr. Binks to charge rendered services to the above account after payment is 30 days past due (60 days from the invoice date).

☐ I authorize Dr. Binks to charge my past due balance at a rate of $_____ per month until paid in full.

_____

Signature