C. Duarte & Associates
1130 Ten Rod Rd. Suite 101
North Kingstown, RI 02852

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1. I am aware that if I cancel an appointment with less than 24 hours, I will be charged **$75.00**.

   Signature: _____

2. Credit Card Authorization I, the undersigned, authorize Psychotherapy Practices of North Kingstown, LLC. (PP of NK) to charge my credit card for psychological services. I also authorize PP of NK to charge my credit card **$75.00** if I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify your clinician at least 24 business hours in advance for a cancelled appointment.

3. I authorize charges to my credit card for the full amount due on outstanding account balances. I understand that PP of NK will be required to disclose information about my attendance and/or cancellation to my credit card company should a dispute arise. This form will be securely stored in a clinical file and, upon request, may be updated at any time. Card Type:

Visa/ MasterCard Card #:
_____

Expiration Date: _____ Verification/Security Code: _____

Name (as printed on card): _____

Billing Address: _____
(Street; City, State & Zip)

Signature: _____
(Patient or financially responsible party)

Date: _____