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CREDIT OR DEBIT CARD AUTHORIZATION

I authorize Karla Benzl, MD to charge my credit or debit card for outstanding payments of services rendered. This includes the full amount due for the sessions the patient attended, as well as for all sessions for which a no-show or late cancellation fee is charged. Unless a different arrangement has been discussed with Dr. Benzl, payments will be charged on the day of service for each session.

For the patient only: I further authorize Dr. Benzl to disclose information about my attendance and/or cancellation to the card holder's credit or debit card company if I dispute a charge.

Name of Patient	
Name Printed on Card	
Card Type (Visa, Mastercard, Discover, Amex)	
Card Number	
Expiration Date	
Verification/Security Code	
Billing Zip Code	

Signature of Card Holder: _____ Date: _____

Signature of Patient: _____ Date: _____