GEOFFREY TAYLOR, M.D.

gpt.psych.md@gmail.com p. 347-396-1002 f. 347-252-9135

FINANCIAL AGREEMENT

PATIENT _____

I understand that payment is due at the time of service, unless otherwise arranged. I understand that although payment can be made in cash, check or credit card, a valid credit card will be required on file in case of non-payment.

I am authorizing Dr. Geoffrey Taylor to charge the following credit card the standard appointment fee at the end of each visit or missed appointment if I fail to provide 48 business hours notice of a cancellation or absence. I provide this authorization from the date of this agreement until I end treatment with Dr. Taylor, or until I otherwise revoke this authorization, which I may do at any time. I understand that while Dr. Taylor accepts cash, check and credit card, payments made by credit card will incur a 2.99% processing fee. I will not dispute charges for sessions I have received or that I have not cancelled with greater than 48 business hours notice.

NAME ON CREDIT CARD _____

☐ American Express ☐ Discover ☐ Mastercard ☐ VISA ☐ Other_____

CARD NUMBER _____

EXPIRATION DATE _____/_____ CVV NUMBER (3 OR 4 DIGITS) _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

I understand and agree to the above terms and conditions:

_____
Signed

_____
Print

_____/_____/_____
Date