KAREN VAUSE M.D., Inc.

I consent to payment for my psychiatric treatment with Dr. Karen Vause with my credit card/check card.

If I choose not to pay via credit card/check card, I do understand that I still need to provide my credit card information as a back-up payment option in the event that my check payment does not clear.

I also understand that Dr. Karen Vause has a 24-hour cancellation policy, and I consent to full session payment by credit card for any appointments that have not been cancelled more than 24 hours in advance.

Credit Card/Check Card Information

Type (**Circle One**): _____***Visa***___***Mastercard***_______

Number: _____________________

Expiration Date: ____________

Credit Card Verification (CCV) Code:______________

Billing Zip Code:____________________

Print Name: _________________________

Sign Name: _________________________ Date:______________