

RAMZI KIRIAKOS M.D., Inc.

I consent to payment for my psychiatric treatment with Dr. Ramzi Kiriakos 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. Ramzi Kiriakos 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: _____