DIMITRY FRANCOIS MD
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Harrison, NY, 10528
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Credit Card Authorization Form

Although Dr. Francois and his team do not participate in any health insurance plans, they will provide you with an invoice to submit for out-of-network reimbursement if your insurance plan allows it. Payment for services is required in full by cash, check, or credit card at the time of visits.

A full session fee will be charged for canceled or missed appointments unless 48 business hours' notice has been given (i.e., an appointment scheduled for Monday at 2 pm would have to be canceled by Thursday at 2 pm in order for a charge not to be incurred). Alternatively, no fee will be charged if an appointment can be rescheduled within the calendar week.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Dimitry Francois MD to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____

Customer Signature

_____

Date