DR. MELISSA SCHACTER

THERAPY

Credit Card Information

Card Holder Name:

Card Holder's Billing address:

Card Number:

Card Expiration Date:

CVV Code : 3 Numbers on back of card: 4 numbers on front of card for AMEX:

I authorize Isaac Farin Therapy, LLC. to charge my credit card ☐

Card holder's signature:_____ Date:_____

Please note that the credit card information form is used to secure your appointment. This information will not be used for payment. Fees will only be collected at the time of service and 4 % processing fee will be applied for all credit cards. If you need to make changes to your appointment please do so 48 hours prior to your appointment in order to avoid a 75$ late/ no-show fee.

Please return this document to drmelissaschacter@gmail.com to confirm your appointment

Thank you!