Bonnie Zucker & Associates, PC
11140 Rockville Pike, Suites 530 & 550-E
Rockville, MD 20852
(301) 881-8818

PERMISSION TO USE CREDIT CARD

Patient Name: ____

By signing this form, I agree to have my credit card charged for services for the patient listed above at the time of service, including charges for missed sessions that are not cancelled within 48 hours prior to the scheduled appointment.

We **do not** store your credit card number. We enter it directly into a secure and encrypted third-party site (Therapy Notes) which is PCI-compliant. Once entered into the system, we can only see the last 4 digits of the number.

Signature: ____

Today's Date: ____