Kara Goobic, PsyD
Clinical Psychologist

8720 Georgia Avenue, Suite 205
Silver Spring, MD 20910

drkaragoobic@gmail.com
Tel: 301 495-6393
Fax: 301-495-6394

Payment information

Circle one: Visa MasterCard American Express Discover

Card Number: _____

Exp: _____/_____ Billing ZIP code: _____

I _____give permission to charge all appointments and
(Cardholder's name)
other fees for _____ to the above credit card. I understand
(client's name)
that I may choose to instead pay by cash or check, but that this card will be kept on file for any outstanding charges. I understand that if I choose to pay with a different card than the one listed above I must submit the request in writing to the office, via Change *of Payment Card* form, which is available from Dr. Kara Goobic

_____ _____
Cardholder's Signature Date

Person Responsible for Payment

Clients 18 years of age or older who would like anyone other than themselves, such as a parent paying for services, to have access to **financial information** at this center, please list their names and sign below.

Name(s): _____ Relationship to client: _____

Address: _____ City, State, ZIP: _____

Home phone: _____ Cell: _____Work:_____

I give Dr. Kara Goobic permission to send encrypted invoices to the following email address. _____I am aware these emails are HIPPA compliant.

Client Signature: _____

Date: _____