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Licensed Psychologist
MD Licens#3917
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Phone: (240) 242-9370
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Payment information

Circle one: Visa MasterCard American Express Discover

Card Number: _____

Security Code _____ 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:_____

Client Signature: _____

Date: _____