Laura N. Antar, MD, PhD, PLLC
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New City, NY 10956
(845) 367-4800

Debit/Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your debit (or credit card). Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time
- No delays in scheduling new appointments

Here's How Recurring Payments Work:
You authorize charges to your Debit Card (preferred) or, with prior permission, your Visa or MasterCard. You will be charged each visit for the total amount due. A receipt will be emailed to you and the charge will appear on your bank or credit card statement. You agree that no prior-notification will be provided if the total payment is the cost of the visit you scheduled. If your bill is more than that amount, you will receive notice from us at least 5 days prior to the payment being collected.

Please complete the information below:

I ________________________________ authorize Laura N. Antar M.D., PhD, PLLC to charge my debit (or credit card).
(full name)

indicated below on the _________ of each scheduled office visit for payment of my office or telepsychiatry visit.
(day or date)

I understand that I will only receive advance notice of the charge if it exceeds the cost of my sessions.

Billing Address ________________________________ Phone# ____________________________

City, State, Zip ________________________________ Email ____________________________

Account Type: ☐ Debit Card **Credit Card requires special circumstance ☐ MasterCard ☐ Visa

Cardholder Name ____

Account Number ____

Expiration Date ______________ Billing Zip Code ______________

CVV (3-digit number on back of Debit/Visa/MC) _______

SIGNATURE ____ DATE ______________________

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.