Sari Halpert MD
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New York NY 10019
phone: 347 868 7612
fax: 727 205 5474

I hereby authorize Dr. Sari Halpert to charge my credit card based on the fee schedule discussed.

____ For one session

____ Every session

____ I prefer to pay by check. I acknowledge that this card will be charged only in the event of non-payment.

I am aware that I may revoke this permission at any time without penalty.

Credit Card Information

Name ____

Number ____

Exp Date ____

CVV ____

Zip Code ____

Signature ____

Date ____