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### **Credit Card Authorization**

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Please complete the following information.

I, \_\_\_\_\_, am authorizing Britton Ashley Arey, MD, MBA to charge  
(print name)  
my credit card in the event that I fail to show for a scheduled appointment, or do not notify Dr. Arey of my inability to attend a scheduled appointment at least 48 business hours in advance, as agreed to in the Treatment Consent Form. Furthermore, for outstanding payments of services rendered, I authorize Dr. Arey to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 48 business hours in advance.

I further authorize Dr. Arey to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one):    Visa    MasterCard

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Verification/Security Code (3-digit code on back by signature line): \_\_\_\_\_

Billing Address: \_\_\_\_\_  
(Street, City, State & Zip)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(client or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time.

Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.