



# **Grelling Psychology Associates**

*sensitive, professional care for individuals and families*

925-215-8694 Phone

925-235-7321 Fax

www.drgrelling.com

## **AUTHORIZATION FOR AUTOMATIC BILLING**

Name of Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_

This document authorizes the staff of Grelling Psychology Associates to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above. Charges will be made to the credit card on or after the dates of service, and will include only those services contracted. Additional services will be billed only as mutually agreed to.

Card Type:  Visa  MasterCard  American Express

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that billed services will be subject to the parameters described in Grelling Psychology Associates' "**Clinical Services - Policies and Procedures**" document, and I have received a copy of and understand these policies.

Signature of Cardholder: \_\_\_\_\_

Date: \_\_\_\_\_

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**Mailing Address:** 21C Orinda Way #141, Orinda, CA 94563  
**Office Address:** 61 Avenida de Orinda #110, Orinda, CA 94563