Do Not Email this form

Fax this form to 973-539-3687 or mail to:

Sharon Ryan Montgomery, Pys.D.
20 Community Place, 4th Floor, Morristown NJ 07960

ONE TIME AUTHORIZATION FOR USE OF CHARGE CARD BY:

DR. SHARON RYAN MONTGOMERY

Please note we accept: Visa, MasterCard, Discover and American Express

Patient/Client's Name ____ (print) Date: ___/___/___

Amount of Charge: ________________________________Date of Charge ___/___/___

Reason for Charge: ____

Visa: ________ MasterCard: ________ Discover: ______ American Express: _______

Card Type: Business or Personal ______________________ Purchase number________

Credit Card Billing Address: ________________________________Zip code _________

Expiration Date: _______________________ 3 or 4 Digit Security Code: _____________

Card Holder's Name: ____

Credit Card Number:____

I give permission to Dr. Sharon Ryan Montgomery to charge the above dollar amount to my credit card. I am aware that, in accordance with the Financial Agreement, all fees and payments are non-refundable. ________ (Card Holder's Initials)

Cardholder's Signature: ____________________________________Date ____/____/_____

DO NOT EMAIL THIS FORM – FAX 973-539-3687 OR MAIL.