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CREDIT CARD AUTHORIZATION

Provider Name: Michael J. Kobel, Ph.D.

Today's Date: _____ Patient's Name: _____

Patient's Phone Number: _____

Visa Mastercard American Express Discover

Credit Card Number: _____ CV Code: _____

Expiration Date: _____

Cardholder's Address: _____

City/State/Zip Code: _____

I understand that my credit card will be billed for office visits, telephone conferences which are over 5 minutes in duration, and any work performed by the doctor which includes but is not limited to writing reports and speaking with other responsible parties regarding your medical care. Unless a check is received at the time services are rendered, my credit card will be charged for these services. I understand that appointment cancellations require 24 business hours notice and that I will be responsible for regular appointment charges should I fail to give 24 business hours notice of cancellation. These policies will remain in effect while I am a patient in this office.

Cardholder's Signature: _____

Cardholder's Name (please print): _____