



DAVID J KOSINS PHD  
*Licensed Psychologist*

## Visa / MasterCard Agreement

I authorize David J. Kosins, Ph.D. to keep my signature on file and to charge my Visa / MasterCard account for the balance of charges not paid by my insurance company within 90 days. Charges to credit cards are made between the 25th and the end of each month. I understand that charges will appear on my credit card statement as coming from “Associates in Behavioral Health Account Services,” which is Dr. Kosins’ billing service.

Please check all that apply:

- All services thus far (total current balance per most recent statement from ABHAS)
- The following specific dates: \_\_\_\_\_
- All future services (Upon your request a statement may be provided to you quarterly.)

Patient name: \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Cardholder address: \_\_\_\_\_

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

Credit Card Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder signature: \_\_\_\_\_ Date: \_\_\_\_\_