

CREDIT CARD AUTHORIZATION FORM

Please indicate the form of payment that you authorize for any services rendered through this practice. Information is securely stored in your clinical file and may be updated upon request at any time.

PATIENT / CLIENT INFORMATION:

NAME:

DATE OF BIRTH:

_____/_____/_____
(Month) (Day) (Year)

ADDRESS:

(Street and Number)

(City)

(State)

(Zip Code)

CELL PHONE:

HOME PHONE:

EMAIL:

CREDIT / DEBIT CARD INFORMATION:

Card Type: Visa Mastercard AMEX Other: _____

Card Number: _____ **Expiration Date:** _____

CARD HOLDER INFORMATION:

Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.

NAME:

ADDRESS:

(Street and Number)

(City)

(State)

(Zip Code)

SIGNATURE OF PATIENT / AUTHORIZED CARD HOLDER

DATE