

***Credit Card Authorization Form***

THIS INFORMATION IS PRIVATE AND CONFIDENTIAL  
AND WILL ONLY BE KEPT ON FILE BY

\_\_\_\_\_

Name as it appears on credit card: \_\_\_\_\_

Phone number: \_\_\_\_\_

Billing address of credit card with zip code: \_\_\_\_\_

\_\_\_\_\_

Email address: \_\_\_\_\_

Card (Choose One) \_\_\_ Visa \_\_\_ Master Card \_\_\_ Discover \_\_\_ American Express

Credit Card Number: \_\_\_\_\_

Expiration Date: Month/Year \_\_\_\_\_

CCV OR CID Code: \_\_\_\_\_

All patients are required to have an active credit card on file. Payment is due at the time of service, or at the session following a "no show" defined as a cancellation with less than 24 hours notice. If you prefer to pay by cash or check, please do so at the time of service, or at the session following a "no show." If payment is not received at the time of service or at the next session following a "no show," we will wait fourteen (14) days for a check to be received by mail. After 14 days your credit card will be charged for any balance due.

I hereby authorize this credit card to be used for payments for services rendered by \_\_\_\_\_. This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to us at:

\_\_\_\_\_.

(Address)

**Please advise us immediately if your card is lost and/or stolen.**

Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_