ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, American Express and Discover. Service fees will be deducted from the designated account at the time services are rendered.
Please also note that a $50 fee will be charged for missed appointments.

Client Information:

Client Name: ____ Date of Birth: _____________________

Address: ___________________________________ City: _____________ State: ________ Zip: ________

Home Phone Number: ________________________ Mobile Phone Number: ________________________

Cardholder Information

Please indicate the name and billing address associated with the credit or debit card you wish to use:

Name as it appears on your card: ____

Billing Address: _____________________________ City: _____________ State: _________ Zip: ________

Email: ____

I authorize and service fees or missed appointment fees to be deducted from the credit or debit card ending in ____________ (Provide the last four digits of the card).

____ _______________________________

Cardholder Signature Date

. . . .

Credit / Debit Card Information:

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your payment has been made.

Card Type: (circle one): American Express Discover MasterCard Visa

Card Number: ____

Expiration Date: _______________________ CVV Number: __________