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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," I 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 me at the above address.

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

Cardholder Signature: _____________________________ Date:__________