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Date: _____

Patient: _____

**PLEASE FILL IN ALL REQUESTED INFORMATION BELOW**

CARDHOLDER'S NAME:_____

CREDIT CARD BILLING ADDRESS:_____

PHONE NUMBER _____

CREDIT CARD: MASTERCARD___ VISA ___ AMERICAN EXPRESS ___DISCOVER___

CREDIT CARD NUMBER:_____

EXP.DATE:_____ CVV#: _____

**I HEREBY AUTHORIZE COMPANY NAME TO CHARGE MY CREDIT CARD ACCOUNT FOR DEDUCTIBLES, CO-PAYS, CO-INSURANCE, LATE CANCELS AND NO SHOW FEES.**

CARD HOLDER'S SIGNATURE:_____

DATE: ___/___/_____

**Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.**