

## 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:**

\_\_\_\_\_

### **CREDIT / DEBIT CARD INFORMATION:**

**Card Type:**  Visa  Mastercard  AMEX  Other: \_\_\_\_\_

**Card Number:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_ **CVV:** \_\_\_\_\_

### **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:**

\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PATIENT / AUTHORIZED CARD HOLDER**

\_\_\_\_\_  
**DATE**