Electronic Payment Authorization Form

Client Information:

Client Name: _______________________________________ Date of Birth: _______________________

Address: ____ City: _____________________________

State: _________ Zip Code: _______________

Home Phone Number: _________________________ Cell Phone Number: ________________________

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use if different from above.

Client Name: _______________________________________ Date of Birth: _______________________

Address: ____ City: _____________________________

State: _________ Zip Code: _______________ E-mail address: ________________________________

I authorize any service fees, missed appointment fees or outstanding balance fees to be deducted from the credit or debit card ending in ______________________ (provide last four digits). I understand that the provider will not use this credit card for weekly co-payments unless discussed in advance. I also understand that if I want the card to be used for fees $30.00 or less a $2.00 processing charge will be added.

_______________________________ _______________________________
Cardholder's Signature **Date**

____
Cardholder's name printed

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 entered into an encrypted payment online program I subscribe to.

Card Type (circle one) Visa MasterCard Discover Health Savings Account Card

Card Number: ____
Expiration Date: ____
Name as printed on card: ____