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Credit Card Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that fees for professional services, products and shipping charges rendered to me will be immediately due and payable. If there is any unpaid balance on my account at any time, it will be charged to my credit card if no other payment arrangements have been agreed upon.

Authorization to debit a credit card:

Patients name: _____

Card Holder's Name: _____

16 Digit Card Number:_____

Visa MasterCard Discover American Express (Please Circle)

Billing Address (Street number only):

_____

Security Code:_____
(3□digit code on back of card)

Expiration Date:_____/_____
(mm/yy)

Billing Zip Code:_____

Please bill charges I incur to the card listed above for services, supplies and shipping. I understand written notification of the dates of service and itemized charges will be sent to me for my records. I have read and understand the above.

Signature: _____

Date:_____