Credit Card Authorization Form

***ALL PATIENTS ARE REQUIRED TO HAVE A CARD ON FILE. ***

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

In the event that I fail to provide 24 hours advanced notice to cancel my appointment or no show to my initial appointment, I understand that my card will be billed for $100.00.

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date