



ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, American Express, Discover, Health Savings Account (HSA) and Flex Spending Account (FSA) credit cards. Service fees will be deducted from the designated account at the time services are rendered or when we receive notice from your insurance company that you have out of pocket expenses (copays, deductible amounts or co-insurance amounts).

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Mobile Phone Number: _____

Cardholder Information:

Please indicate the name and address associated with the card you wish to use.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

I authorize the payment of service fees using my credit, debit, HSA or FSA card ending in _____
(Provide the last four digits of the card)

Cardholder Signature

Date

Credit/Debit Card Information:

Please provide your card information below. The bottom portion of this form will be destroyed once the information is entered into our secure credit card processing company.

Card Company: (circle one): American Express Discover MasterCard Visa

Card Type: (circle one): Credit Debit FSA HSA

Card Number: _____

Expiration Date: _____ CVV Number: _____