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Credit Card Payment Authorization

It is my policy to have a credit card on file for all my patients. If you wish to have your credit card charged for all future appointments please check the line at the bottom of this authorization form. I accept all major credit cards and use Square Card to complete the transaction.

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

(For AMEX it is the four numbers on the front of the card)

I understand that I will be charged at my regular fee for missed appointments and appointments cancelled with less than 24 hours notice. Additionally, if my account is overdue by 30 days, I understand that my outstanding balance will be charged to the above credit card.

Name:_____

Signature: _____

Date: _____

Billing Address: _____

City:_____

State: _____ Zip Code: _____

Email: _____

Phone Number: _____

CHECK HERE IF YOU WISH ALL APPOINTMENTS TO BE CHARGED ☐