
COMPANY NAME

123 Park Avenue

Michigan 69789 MI

(123) 456-7899

# Credit Card Authorization Form

We require a credit card on file. The credit card will be automatically charged for the balance of any outstanding accounts that are not settled within 60 days of service.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date: |  |  | - |  |  | - |  |  |  |  |  |  |
|  |
| Your Name: |  |  |

## Payment Agreement

|  |  |  |
| --- | --- | --- |
| ***I will pay at the time of service*** |  |  |
|  |
| I will pay an estimated amount of my financial responsibility with each visit. I understand that this is just an estimated amount and the actual amount due may be more or less than what is collected. Any overpayment will be refunded upon full processing of all claims. |
|  |
| ***Please bill me*** |  |  |
|  |
| I understand my credit card will automatically be charged for any balance due that is not paid on the due date on my statement. I also understand that if my credit card is due to expire while in treatment, and new card information is not supplied before the expiration date, an estimated amount will be applied to my credit card for all past appointments.  |

## Credit Card Information

|  |  |
| --- | --- |
| Name as it appears on the card: |  |
|  |
| Type of Card: |  | Visa |  | MasterCard |  | Discover |  | American Express |
|  |
| Credit Card #: |  |  |  |  | - |  |  |  |  | - |  |  |  |  | - |  |  |  |  |  |
|  |
| Security Code (located on the back of Visa / MasterCard: (3 digits): |  |  |  |  | Exp. Date: |  |
|  |
| Street: |  |
|  |
| City: |  | State: |  | Zip Code: |  |
|  |
| Phone: |  |  |  |

## Authorization

I hereby authorize this card to be used for service charges at COMPANY NAME.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Cardholder Signature: |  | Date: |  |
|  |  |  |  |

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