Payment / Credit Card Authorization

Patient Name : Last Name :_____ First Name :_____ Middle Name :_____

Email address : _____SSN :___-___-____

Home address : _____ APT# : _____ City : _____ State : ___ Zip : _____

Telephone : Home # : **(___) - ___ - ____** Cell # : **(___) - ___ - ____** Work # : **(___) - ___ - ____ Ext:** ____

☐ We require a credit card number on file to process any balance remaining after your insurance company has paid. Estimated copayments are due at the time of service.

Name of credit card : _____

Number : _____

Expiration date : Year : _____ / Month : _____

Signature : _____

Date: _____

To be signed at the time of the appointment by the Credit Card holder