Center for Integrative Healthcare

CREDIT CARD AUTHORIZATION

I authorize The Center for Integrative Healthcare to charge my credit card as noted below for all missed appointments, cancellations without 24 hours prior notice, appointments in which no other form of payment is readily available, and other services rendered.

Patient's Name: _____

Parent/Guardian (if applicable): _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Email Address: _____

Credit Card: _____ Visa _____ MasterCard _____ Discover _____ American Express

Name As It Appears on Credit Card: _____ C

redit Card Number: _____

Expiration Date: _____

Security Code (on back of card): _____

Billing Zip Code: _____

Signature: _____ Date: _____