Paying for Your Care Authorization Form

VISA / MASTERCARD / DISCOVER/ AMERICAN EXPRESS

Date: _____

Credit Card #:_____

Exp. Date: _____/_____ CVV #:_____ (3-digit code on the back of card)

Patient Names: _____

Cardholder's Name (if different):_____

Address (Street # or PO Box associated):_____

Zip Code: _____ Phone Number: _____

Please choose one of following two options:

☐ Option #1

I, _____, will pay after every visit.

☐ Option #2

I, _____, understand that my credit card will be run ☐ daily, ☐weekly, ☐biweekly, or ☐ monthly for the total amount due or for payments of $_____ until the balance is zero.

Card Holder's Signature: _____ Date: _____

For Life Wellness Center Purposes Only:

Received by: _____