Patient Name:_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV: _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Email Authorization

We need an Authorized Email Address to keep on file for you and or your child.

****Patient name:** _____

**Responsible Party: ☐ Self ☐ Other: Mother/Father

**Name: Parent or Guardian:

_____

**Email address:_____

(Please Print clearly)