**Credit Card Authorization Form**

By signing below, I authorize the following credit card number to be billed for co-pays, coinsurance, deductibles, the 3 % credit card surcharge, and for charges for appointments not cancelled with at least 48 hours’ notice.

1. Card # \_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_
2. Expiration Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_
3. Security Code: \_\_\_\_\_\_\_\_\_\_
4. Zip Code of Address Linked to Card: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Parent/Guardian Date