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CREDIT CARD AUTHORIZATION

This credit card authorization form is confidential and is used to hold your appointment. If you fail to cancel your appointment in advance of 48 business hours, you will be charged the full consultation fee as stated in our Appointment Cancellation Policy.

If you would like us to keep your card on file for your conveneince (ordering supplements, paying for future appointments/programs) please check the box below.

☐ I authorize permission to keep my creidt card on file. I will notify the office to charge my card on file for any appointments, programs, or supplements that I order.

Name: ______________________________

Address: ______________________________

City:______________ **State:**__________ **Zip:** __________

Phone Number:______________________________

Credit Card: (Visa OR Mastercard Only)

☐ **Visa**
☐ **MasterCard**

Credit Card Number: ______________________________

Expiration Date: ______________ **3 Digit Security Code:** __________

Credit Card Billing Address:

☐ Check the box if your billing address is the same as the address above.
If it is not the same please enter it below.

Billing Address: ______________________________

City:______________ **State:**__________ **Zip:** __________