CREDIT CARD AUTHORIZATION FORM

FIT FOR LIFE CHIROPRACTIC CENTER
74 HORSENECK ROAD
MONTVILLE, NJ 07045

Our office requires that a credit card be kept on file for payment on any co-payment, co-insurance, deductible, or charge that may or may not be covered by your health insurance. This form will be kept confidential, and only authorized staff has access to the information

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD #: _____

EXPIRATION DATE: _____/_____ VERIFICATION CODE (3 OR 4 DIGITS): _____

PLEASE PROVIDE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Fit for Life Chiropractic Center to charge the above credit card account for any co-payment, co-insurance, deductible, and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices, and receipts via the email I have provided to this office. If I am an uninsured patient, I authorize payment at the time of service. I agree to update an information regarding this credit card account.

_____ _____

Cardholder signature Date