PAYMENT AGREEMENT AND CREDIT CARD AUTHORZIATION

Payment

Payment must be made prior to or at the time of each visit. We accept cash, check, Mastercard, and Visa as forms of payment for services. There will be a 3.5% convenience fee assessed for credit card transactions.

If the Patient is not the payor or card holder, the payor must execute this Agreement along with the Patient and/or legal guardian, confirming that the card holder/payor consents to the charges applied to such credit or debit card account.

Patient Acknowledgement & Acceptance of Credit Card Authorization

By signing and submitting this form to the practice, I acknowledge, affirm, and certify the following:

I have read this Payment Agreement and Credit Card Authorization carefully.

I have filled in this form completely and to the best of my ability.

Patient Name _____

Patient or Parent/Guardian Signature _____

Date _____

Card Holder/Payor Information

I understand that in order for the practice, its subsidiaries. or agents to extend credit. I am required to provide a working credit card, which will be kept on file. By completing this form, I authorize the practice to process my card below, the updated card on file at the time of the transaction, or the individual's card for which I have obtained authorization from for payment owed when it becomes due.

Patient Name _____

Credit Card Holder's Name _____

Relationship to Patient _____

Credit Card Holder's Address _____

Credit Card Holder's Phone Number _____

Credit Card Holder's Email _____

Credit Card Type _____

Credit Card Number _____

Expiration Date _____

I hereby give consent to charge my credit/debit card submitted to pay for any payments of Patient when they become due.

Credit Card Holder's Signature _____

Today's Date _____