



Credit Card Authorization Form

Cardholder's Name: _____
(as it appears on card)

Account Name: _____
(if different than cardholder)

Visa / MasterCard / Discover Card / American Express / Care Credit (please circle)

Card Number: _____

Expiration Date: _____ Security Code: _____
(on back of card – 3 or 4 digits)

I understand and agree that any past due balance (over 30 days from date of service) on my account will automatically be billed to my credit card I also understand and agree that this authorization to pay any past due balances with my credit card remains in effect until cancelled by me with 30 days written notice.

A finance fee of 1.75% per month (21% annual) is assessed on balances over 30 days old.

Cardholder Signature

Date