CREDIT CARD AUTHORIZATION FORM AND INFORMATION

Credit card information must be submitted so that it can be used for all future appointments.

Your card will also be charged at the time of the missed appointment, if **24-hours notice** was not given of the cancellation or rescheduling of appointment. Your credit card information will be kept private. This option is provided for your convenience and authorization will be revoked upon your request.

Authorization

By signing below, I, _____ authorize **Complete Care Physicians** to charge my credit card for future appointments and for the full amount of each missed appointment (**$50.00- NON CANCELLATION FEE**) for which adequate notice of cancellation was not given.

Credit Card Information

Credit Card Type (check one): __ AmEx __ Discover __ MasterCard __ Visa Credit __ Debit
Card Number: _____
Credit Card Expiration Date: _____

Security Code (3 digit number on back for V/MC/D, 4 digit number on front for AmEx): _____

Billing Street Number and Name:_____

Billing Zip Code: _____

Card Holder's Signature _____ Date _____

Card Holder's Name (Printed) _____

Patient's Name, if not same as Card Holder _____