# Consent for Credit Card Authorization

I, _____, hereby authorize Dr. Kracke and Associates to keep my signature on file and to charge the credit card selected below for the following:

☐ Recurring charge of $_____ to be charged every (circle one of the following) session/week/month/other _____.

☐ Balance remaining after claims have been resolved with insurance, not to exceed $_____.

☐ Monthly balance due to be charged on the _____ of each month.

This authorization will be in effect for **one year** from the date of the signature,

-or- if you would like other effective dates please specify below:

From _____ To_____

Names of the patients or family members covered by this authorization are:

1) _____ 2) _____

3) _____ 4) _____

Card Type: □ Visa® □MasterCard® □Discover® □HSA

Cardholder Name: _____

Cardholder Address: _____ City: _____ Zip: _____

Phone Number: _____ - _____ - _____

Credit Card Number _____ _____ _____ _____

Expiration Date: _____/_____ CVV three-digit code: _____

Cardholder Signature: _____ Date: _____

** ☐ Please check here if you would like us to send you a copy of your receipt.