KETAMINE HEALTH &
RESTORATION

Credit Card Authorization Consent Form

Name on Credit Card: _____
Credit Card Number: _____
Expiration Date: _____
CVV Code: _____
Billing Address: _____

What email address will you prefer the receipt to be sent to?_____

The card provided will not be used for appointments, sessions, and services unless they are overdue by more than 30 days, or for other reasons as stated in the Financial Agreement.

I understand that this card will be charged for no-show or late cancel appointments at the fee stated in the Office Policy and Procedures/Financial Agreement, and I have read and agreed to abide by that.

I hereby authorize Ketamine Health & Restoration, to charge the Credit Card provided for automatic charge for late-cancel or no-show fees, bounced checks, or for balances that are overdue by one month.

I understand that this form is valid until I provide written notice that it is revoked. I also understand that if I change credit cards, I will supply Lifetime Insight the new credit card information.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in the Offices Policies and Procedures/Financial Policies form.

I further authorize Ketamine Health & Restoration to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Signature: _____ **Date:** _____