CREDIT CARD AUTHORIZATION FORM

Patient Name: _____ D.O.B._____

I understand that appointments will not be scheduled until all forms have been read, completed, and signed, and a credit card is on file to secure appointment times. The card provided will be used to secure payment for the appointments, services, and fees (including the no show/late cancellation fee) as described in the "Patient Services Agreement," that I have read, understand, and agree to abide by.

By signing this form, I hereby authorize Dr. Holly Peek, MD/MPH to charge the following Credit Card. I have been duly informed of the policies and procedures as they were outlined to me in the "Patient Services Agreement" and above. I am hereby aware of the treatment and charges and agree to assume full financial responsibility.

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 Dr. Holly Peek, MD/MPH with 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 "Patient Services Agreement." I further authorize Dr. Holly Peek, MD/MPH to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Number:

Expiration Date:

Cardholder Name:

CID (last 3 digits on back):

Billing Address:

Billing City, State, Zip:

Patient/Cardholder Signature: _____

Financially Responsible Party (if different from patient):_____

Date:_____