Credit Card
Pre-Authorization Form

Patient Name: _____ Date: _____

Patient DOB: _____

Patient Address: _____

The undersigned Patient/Cardholder hereby authorizes Balanced Solutions PLLC to obtain payment for fees for services from the Patient/Cardholder's credit card/debit account identified below. Balanced Solutions PLLC may charge the account for missed appointments (minimum of 24 hrs cancellation notice is required please), without requirement of the Patient/Cardholder's signature for each payment. If any appointment is missed without cancellation, or an appointment cancelled outside the 24 hour notification window, a **missed appointment fee equal to appointment charge will be automatically assessed.**

By signing this form, the Patient/Cardholder acknowledges and agrees to the following:

- This signed form is confidential and will be kept in a secure location at Balanced Solutions PLLC.
- The Patient/Cardholder authorizes Balanced Solutions PLLC to automatically charge the below-referenced Credit Card any remaining balance on the above-named patient's account (including copays, co-insurances, deductibles or missed appointment fees).
- The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.
- Credit Card payments will appear on your statement as Balanced Solutions PLLC.
- This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30 day notice of revocation.
- This authorization serves as agreement for receipts to be noted "signature on file" when charged

Name on Card: _____

Credit Card #: _____

CVV Number: (3 digits on back of card): _____Expiration: _____

Billing Zip Code: _____

Printed Name of Authorized User: _____

Patient/Cardholder Authorized Signature:_____

Date: _____