# Credit Card on File Authorization Form

Patient Name:_____ Date of Birth:_____

- By signing below, I authorize The WellBridge Clinic to keep my signature and my credit card information securely on file in my account.
- I authorize The WellBridge Clinic to charge my credit card for any outstanding balances when due.
- If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give The WellBridge Clinic a new, valid credit card which I will allow them to charge over the telephone.

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|---|
| Visa □ MasterCard □ Discover □ American Express □ |
| Name on Card (Print): _____ |
| Credit Card Number: _____ Exp. Date: ___/____<br><br>Security Code_____ |
| Credit Card Holder's Signature: _____ |
| Cardholder Zip Code (from cardholder billing address):_____ |

_____ **(Initials)** I authorize a late cancelation charge, in the event that I cancel with less than 48 hours notice, against my credit card for $50.00 for the first occurrence, $85.00 for each subsequent occurrence.

_____ **(Initials)** I authorize a no-show charge, in the event that I do not appear for my scheduled appointment, against my credit card for $50.00 for the first occurrence, $85.00 for each subsequent occurrence.

_____ _____

Signature Date