wellnessarchitecture
DESIGNING OPTIMAL HEALTH

Credit Card Authorization Form One-Time & Repeat Payments

Cardholder Information

Name:_____

Billing Street Address:_____

Street Address (cont.):_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Address:_____

Direct Telephone: (_____)_____-_____

Patient Information

Patient Name & Services Covered:_____

_____

_____

_____

□ I authorize a one-time charge against my credit card for the follow amount $_____

□ I authorize a recurring charge against my credit card for the following amount

$_____ once every _____ day(s)/week(s)/month(s)/year(s) beginning

_____/_____/_____ and ending after_____ payments.

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number:_____

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_____ Date___/___/___Security Code:_____