CREDIT CARD AUTHORIZATION FORM

PLEASE FILL OUT ALL INFORMATION BELOW

CARDHOLDER INFORMATION		
PATIENT NAME:		
CARDHOLDER NAME (IF DIFFERENT THAN PATIENT):		
ADDRESS:		
CITY:	STATE:	ZIP
TELEPHONE:	ALTERNATE PHONE:	
BILLING ADDRESS (IF DIFFERENT FROM ABOVE):		
CITY:	STATE:	ZIP:

PAYMENT AUTHORIZATION
CARD TYPE: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS
CARD NUMBER: _____
EXPIRATION DATE: _____ /_____
CARD IDENTIFICATION NUMBER: _____ (3 DIGITS ON THE BACK OF YOUR CARD NEAR SIGNATURE PANEL OR 4 DIGITS ON FRONT FOR AMERICAN EXPRESS)
PRINTED NAME: _____ SIGNATURE: _____ DATE: _____

While you can pay by check or cash, Gabriela Portas, LCAT requires a credit card on file for all patients. If paying by check or cash, this card will only be charged for missed appointments or cancellations made with less than 48 hours notice.

PREFERRED PAYMENT METHOD:

□CREDIT CARD ON FILE □ CHECK □ CASH