

CREDIT CARD AUTHORIZATION FORM

Please indicate the form of payment that you authorize for any services rendered through North Shore Relationship Center and CS Medical Associates. Information is securely stored in your clinical file and may be updated upon request at any time.

After the first declined transaction, our office will attempt to contact you via phone and email. All future appointments will be canceled until payment is obtained. An attempt to charge your card will be made every 24 hours for a 72 hour period. If the decline occurs on 3 separate occasions, you may be discharged from the practice.

PATIENT / CLIENT INFORMATION:

NAME:

CREDIT / DEBIT CARD INFORMATION:

Card Type: Visa Mastercard AMEX Other: _____

Card Number: _____ **Exp. Date:** _____

CVV: _____ **Billing Zip Code:** _____

CARD HOLDER INFORMATION:

Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.

NAME:

The Undersigned agrees and authorizes to charge my credit card account on file for any and all unpaid balances remaining outstanding, as well as for any scheduled appointments that have been canceled, broken, "no-showed" without the 24-hours (week-ends do not apply) prior advanced notice.

SIGNATURE OF PATIENT / AUTHORIZED CARD HOLDER DATE
