

Credit Card Information and Authorization

I, (print name) _____ authorize Michael Madden D.C. to bill my credit card as listed below.

Name on Credit Card _____

Credit Card Holder's Billing Address (Where your statement is mailed.)

Credit Card Details

Visa Card # _____ Exp date _____

MasterCard Card# _____ Exp date _____

Amex Card # _____ Exp date _____

Last 3 digits (4 for Amex on front) on back of card _____
(found on the back of your credit card on the signature panel)

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization

Card Holder's Signature

Today's Date

Patient's Signature

Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.