Balance Connection

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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, American Express, Discover, Health Savings Account (HSA) and Flex Spending Account (FSA) credit cards. Service fees will be deducted from the designated account at the time services are rendered.

Client Information:

Client Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Mobile Phone Number: _____

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

I authorized any service fees to be deducted from the credit or debit card ending in _____
(Provide the last four digits of the card)

_____ _____
Cardholder Signature Date

Credit/Debit Card Information:

Please provide your payment information below. The debit or credit card information you provide on the bottom portion of this form will be destroyed once your first payment has been made.

Card Type: (circle one): Visa MasterCard American Express Discover HSA FSA

Card Number: _____

Expiration Date: _____ CVV Number: _____