Credit Card Authorization Form

CANCELLATIONS AND NO-SHOWS:
Appointments cancelled with less than 24 business-hours notice will be subject to a fee of $100, which is not reimbursable by insurance, and will be automatically charged to the credit card provided. _____(initial)

PAYMENT DUE AT TIME OF SERVICE:
Therapydia will provide a current account balance at each visit that may be paid by credit card, check or cash. You will also receive a monthly account statement. Therapydia stores credit card information securely and will automatically charge balances older than 30 days. If you have any questions regarding your balance, please call our office manager as soon as possible. _____(initial)

CARD ON FILE: Authorization Form
Information to be completed by cardholder: The undersigned agrees and authorizes medical practice to save the credit card indicated below on file.

Medical Practice: _____

Patient's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card:

- ☐ MasterCard
- ☐ Visa
- ☐ Discover
- ☐ Amex

Last 4 Digits of Card: _____

Expiration Date: _____

I, authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

Cardholder's Signature _____ **Date** _____