

Credit Card Authorization Form

In an effort to better serve you and your child, we ask that you take care of the fees for your child's care at the time of service. By allowing us credit card authorization, you are allowing us to charge any balance due on the date of service and/or a balance which is past due by 30 days.

Authorization:

I authorize Dr. McCandless to keep my signature on file and to charge my () American Express () MasterCard () Visa credit card for any balance due on the day of an appointment in her practice or which is overdue past 30 days. **(You will be contacted prior to any charges being applied to your credit card).**

Parent Signature

Date

Patient Name _____

Cardholder Name _____

Cardholder Address _____

City _____ **State** _____ **Zip Code** _____

Credit Card #1 Number: _____ **Exp Date** _____

Credit Card #2 Number: _____ **Exp Date** _____

Cardholder Signature: _____

If you do not wish to give us credit card authorization we will collect upfront for all services and allow the insurance company to reimburse you directly.