



Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize _____, and **ProfessionalCharges.com**,
to charge my credit/debit card for professional services as follows:

- Initial*
_____ This visit only, for the amount of \$ _____ .
- _____ All visits in the next 12 months, beginning ____ / ____ / ____ ,
not to exceed \$ _____ total.
- _____ Recurring charges, date(s) of service ____ / ____ / ____ to
____ / ____ / ____ , not to exceed \$ _____ ,
____ monthly, ____ semimonthly, ____ weekly, ____ per visit.
- _____ **To charge my card for the balance of fees not paid by my insurance
company within 90 days, as indicated above.**

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover.

Card Number _____ - _____ - _____ - _____ ,

CVV Number _____
A 3-digit number in reverse italics
on the **back** of the credit card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

Street City State Zip

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____, Date ____ / ____ / ____

Charges will appear on your credit card statement as an abbreviation of
ProfessionalCharges.com.