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.

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