Name of Patient: ______________________________ Birthdate: _________

This document authorizes the staff of *The Clinic* to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above.

Card Type: ☐Visa ☐Mastercard ☐Amex ☐Debit

Card Number: ________________________________ Exp. Date: _________

Name on Card: _______________________________ Security Code: ______

Billing Address: ____

City: ____________________________ State: _________ Zip: _________

I understand that billed services will be subject to the parameters agreed upon between myself and my treating clinician and outlined in the "Policies and Procedures Agreement." I have received a copy of this agreement and understand these policies.

Signature of Cardholder: __________________________________

Date:_______________

THE CLINIC
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