Credit Card Authorization Form

Your private credit card information is kept secure

You will never be charged without your authorization

Patient's Name (printed):_____

Credit Card Information: _____ VISA _____ MasterCard _____Discover

Credit Card Account #: _____

Cardholder's Name as it appears on card:

_____

Security Code: This is a 3-digit code on the back.

Security Code #:_____ Expiration Date: Month:_____ Year:_____

Relationship to Patient: _____

Complete Billing Address

Street:_____

City:_____ State:_____ Zip Code:_____

Telephone:(___)_____

Email: _____

I authorize Gloria Phillips, D.C. to charge the above listed credit card for professional services, which includes face-to-face, telephone, and email consultation fees, as well as charges for review of records, re-evaluation, or revision of treatment plans, evaluation of diagnostic studies, report writing and herbal and nutraceutical supplements and supplies as well as missed appointment and late payment and bank fees as indicated by my signature below: