Credit 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, ☐ Medical Flex/Savings

Credit 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*

Card Holder Signature _____, Date ____ /_____ /____

Charges will appear on your credit card statement as ***ProfessionalCharges.com.*** *or some abbreviated form of it.*

ProfessionalCharges.com
1530 E. Chevy Chase Dr., Ste. 209
Glendale, CA 91206

Phone: (818) 206-2126
E-mail: admin@ProfessionalCharges.com