Credit Card on File Authorization

Patient Name: _____ DOB: _____

I hereby authorize Flaton ADDept Center to process my Visa, MasterCard, Discover or AMEX the day of or within 24 to 72 business hours after services are rendered. I understand that my information will be securely stored for future transactions on my account. I understand that I will be charged $150 per half hour or $300 per hour for appointments missed or not cancelled before the forty-eight business hours. This authority will remain in effect until cancelled by either party within 30 days written notice.

Card Type

- ❑ Visa
- ❑ MasterCard
- ❑ Discover
- ❑ AMEX

Cardholder Name: _____

First MI Last

Cardholder Address: _____

Address City State Zip

Card Number: _____

Expiration Date _____

Security Code _____

Billing Zip Code _____

Receipt:

- ❑ Email _____
- ❑ Text _____
- ❑ None

Cardholder Signature _____ **Today's Date** _____