



**CREDIT CARD AUTHORIZATION AGREEMENT
FOR**

_____ Patient's Name

Credit Card Information: (as shown on credit card)

Credit card type: Visa MasterCard Discover

Card Holder Name (as shown on credit card): _____

Credit Card #: _____ - _____ - _____ - _____ Expiration Date: ____ / ____

Billing Address of Credit Card Holder: _____
street address

_____ city state zip

Phone Number of Credit Card Holder: (____) _____

This agreement will be in effect from ____ / ____ / ____ - December 31, 2009
(today's date)

Authorization:

I hereby authorize 3-C Family Services, P.A. (3-C FS) to charge the indicated credit card on a periodic basis to collect payment due for services rendered by 3-C FS in accordance with the 3-C FS Fee Schedule for the above listed patient. I also authorize 3-C FS to charge my credit card the price of a scheduled session, in accordance to the 3-C FS Fee Schedule, should the above listed patient fail to attend their scheduled appointment or fail to give a 24 hour notice to cancel their appointment. If 3-C FS is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. I understand that this agreement shall remain in force unless I cancel it in writing. I will not dispute 3-C FS's charges to my credit card so long as the amount in question was for services rendered prior to my canceling my account in the manner required. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with 3-C FS. I acknowledge that I have read and agree to all of the above terms and conditions.

Signature of Credit Card Holder (Required)

____ / ____ / ____
today's Date

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.