Credit Card Authorization Form

I authorize charges to my Visa, MasterCard, American Express or Discover card. A receipt will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided. We will only charge your credit card for the following reasons:

- Payment for an Office Visit or any services rendered by Dr. Kimberly Sackheim
- Payment was sent to you by your insurance carrier that should have been sent to Dr. Kimberly Sackheim
- No show fee ($100)
- Late Cancellation Fee (a **24 hour** cancellation notice is required for office visits and a **48 hour** cancellation notice is required for any procedures scheduled at the surgery center with Dr. Sackheim. Any cancellations made within less than 48 hours will result in a $100 cancellation fee

Please note, there is a 3% credit card processing fee for all credit card transactions.

Please complete the information below:

I ______________________________ authorize **Spine & Pain Total Care**, to charge my credit card

(full name)

for any payment that I may receive from my insurance carrier for services that were rendered to me

by Dr. Kimberly Sackheim.

I understand that it is my responsibility to inform the office of any changes to my credit card to avoid a penalty fee if my credit card should decline for whatever reason.

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover ☐ FSA/HSA

Cardholder Name ____

Account Number ____

Expiration Date _____________

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) ______ Zip code ____________

☐ **I do not wish to leave my credit card on file. I understand that I will be responsible for making sure any payments to Spine & Pain Total Care are received in a timely manner.**

SIGNATURE ____ DATE _____________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.