

The Personal Wellness Center

6508 Deer Point Dr Suite 4C, Salisbury, MD 21804

Telephone: 410-742-6016

Credit Card Authorization Form and Agreement Co-pays, Deductibles and Cancellation Fee

Date:			
Card Holder Name (as shown on credit card):			
Billing Address:			
City:	State:	Zip code:	
E-mail:	Phone:		
Credit Card Type:	<input type="radio"/> Visa	<input type="radio"/> MasterCard	<input type="radio"/> Discover
Card number:	Expiration date:		
Security Code:			
<p><u>AUTHORIZATION TO CHARGE CO-PAYS, DEDUCTIBLES AND CANCELLATION FEES</u></p> <p>By signing this form, I, _____, certify that this is my credit card and hereby authorize The Personal Wellness Center® to charge the indicated credit card for any fees associated with co-pays, deductibles and cancellation fees for the services rendered in this office. I understand that if I miss my scheduled appointment without 24 hrs. notice, I will be charged the full service fee, unless there is a last minute emergency (i.e; illness, accident, etc.) I agree that any remaining balances, after insurance payment, are my responsibility, and it will be charged to my credit card if not paid on time. I agree that if any problems or questions regarding this agreement or any services provided by The Personal Wellness Center®, I will contact this office for assistance.</p>			
_____ Signature of Card Holder		_____ Date signed	