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: ○ Visa	○ MasterCard	○ Discover
Card number:		Expiration date:
Security Code:		

AUTHORIZATION TO CHARGE CO-PAYS, DEDUCTIBLES AND CANCELLATION FEES

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 a $75 cancellation 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.

_____ _____

Signature of Card Holder **Date signed**