Optional Credit / Debit Card Payment Consent Form

As a courtesy we can keep your credit card information on file for outstanding charges. You may revoke this <u>optional</u> agreement at any time.

Patient Name		
Last		First
Name on card if different		
I authorize Shar	on Burge to charge my card for p	rofessional services as follows:
Initial		
To charge my card for the	balance of fees including deductib	oles, copayments or co insurance amounts.
Not to exceed \$	per visit.	
	Master card Discover	•
Expiration Date:		
CVV Number:	(3 digit # on back of card or 4 dig	git # on front of card for American Express)
Zip Code of Billing Address		
A receipt for payment can be issued	l to you via email or text to your ce	ell phone
Card Holder Email Address:		
Card Holder Cell Phone Number: (_)	
Card Holder Signature:		Date: