Fairfield Family Health

Payment Policy: Credit Card Authorization Form

Date____/____/____

Our office accepts cash, checks and credit cards for services rendered. We request a credit card be put on file to secure all scheduled appointments. No charges will be applied to your credit card unless you miss or cancel an appointment without prior notice (2 business days). This information will be kept confidential. On the day of your scheduled appointment, charges for consultations, supplements, etc. will be itemized and reviewed with you. Payment is due on the day of service. Phone consultations/telehealth or video consults will be billed to your credit card on the day of your appointment.

Name exactly as it appears on credit card:

_____

Type of credit card: ☐ Visa ☐ Master Card ☐ Discover☐ AMEX

Credit Card number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CVV _____

I hereby authorize Fairfield Family Health to charge my credit card for any medical or dispensary services rendered, as described above. I understand that by signing this authorization, I am giving permission for Fairfield Family Health to use my credit card as payment for such services, unless I make other arrangements to make payment. I reserve the right to withdraw the use of this credit card at any time by giving written notice to Fairfield Family Health. I additionally understand that I am responsible for updating Fairfield Family Health of any changes or cancellation of this credit card that may alter the use of this card. **I have read and understand the statement regarding the use of my credit card.**

_____ _____

Signature Date

(Parent signature if under 18 years of age)