

## Credit Card Payment Consent Form



Patient Name \_\_\_\_\_  
*Print Last First Middle Initial*

Name on Card if different \_\_\_\_\_

I authorize \_\_\_\_\_, and **ProfessionalCharges.com**, to charge my credit/debit card for professional services as follows:

*Initial*

\_\_\_\_\_ This visit only, for the amount of \$ \_\_\_\_\_.

\_\_\_\_\_ All visits in the next 12 months, beginning \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

not to exceed \$ \_\_\_\_\_ total.

\_\_\_\_\_ Recurring charges, date(s) of service \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ , not to exceed \$ \_\_\_\_\_.

\_\_\_\_ monthly, \_\_\_\_ semimonthly, \_\_\_\_ weekly, \_\_\_\_ per visit.

\_\_\_\_\_ **To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card:  Visa,  MasterCard,  Discover,  Medical Flex/Savings

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, CVV Number \_\_\_\_\_  
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date \_\_\_\_\_

Card Holder's Billing Address for Credit Card Statements

\_\_\_\_\_  
*Street City State Zip*

Card Holder Signature \_\_\_\_\_, Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Charges will appear on your credit card statement as **ProfessionalCharges.com**.  
or some abbreviated form of it.*

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