

Credit Card on File Authorization

(Required for All New Client Accounts)

CLIENT

First _____ M.I. ____ Last _____

PERSON RESPONSIBLE FOR PAYMENT (if not the same)

First _____ M.I. ____ Last _____

TYPE OF CREDIT CARD

Visa MC AmEx Discover Other _____

Credit Card # _____

Expiration Date _____

Card Code _____ (3 digits on back of Visa, MC, Discover | 4 digits on front of AmEx)

Zip Code _____ (billing zip code)

NOTE: The charge on your card will appear as “BELLAGIOPSY.”

I authorize payment for services rendered, on any balance due on my account, and for any missed appointments for which a 24-hour cancellation notice was not given.

Client Signature

Date

OR

Person Responsible for Payment Signature

Date