# Fox Clinical Services

Credit Card Authorization Form

Fox Clinical Services, LLC requires that all patients have a credit card on file. This conveniently assists in the collection of patient responsibilities at the time of service and minimizes the need for other billing. Account numbers are kept secure. At any given visit you may choose to pay by cash, or check, or defer to the credit card on file. You may also revoke this agreement in writing at any time. Your cooperation is much appreciated.

Card Holders Name: ___________________________

Credit Card Number: ___________________________

Expiration Date: ____________

3 Digit Security Code on back of card (4 digits on front of AmEx): ___________

Billing Zip Code of Credit Card:_____________

Type of Card: Visa, MasterCard, AmEx, Discover, Flex spending ______________

Card Holders' Signature:_________________ Date:____

Card Holder Phone number:______________

_____ (initial) I understand that by signing above, I am authorizing Fox Clinical Services, LLC. to charge my credit card for balances 90 days past due. These balances may include unpaid co-pays, co-insurance amounts, deductibles, and/or charges for missed/late cancelled appointments. I understand that Fox Clinical Services, LLC. can provide me a statement as well as a receipt for any charges that are applied to the credit card upon request. Fox Clinical Services, LLC. will contact me if my card is declined or expired should I fail to update.

Client Signature__________________________________ (12 and over) Date___________

Guardian Signature _______________________________(if applicable) Date____________