Complete Care Physicians

CREDIT CARD AUTHORIZATION FORM AND INFORMATION

Credit card information must be submitted so that it can be used for all future appointments.

Your card will also be charged at the time of the missed appointment, if **24-hours notice** was not given of the cancellation or rescheduling of appointment. Your credit card information will be kept private.

Authorization

By signing below, I, _____ authorize **Complete Care Physicians** to charge my credit card for future appointments and for the full amount of each missed appointment (**$50.00- NON CANCELLATION FEE**) for which adequate notice of cancellation was not given.

By signing below, I, _____ authorize **Complete Care Physicians** to store the Credit Card information in the Credit Card Reader for future payments.

Name (Print) _____

Signature: _____

Date: _____