

Dr. John Beiter
650 East Big Beaver Road, Suit A
Troy, MI 48084

Charge Authorization Form

Name [as it appears on credit card]: _____

Client Name[s]: _____

Zip Code for Cardholder: _____

Credit Card Account Number:

____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____

Expiration Date: ____ / ____

3 or 4 [American Express] Digit Security Code [Back of Card] ____ ____ ____ ____

Co-pay \$ ____ ____ ____ . 00

PRE-ARRANGED PAYMENT AUTHORIZATION AGREEMENT

I hereby authorize and allow Dr. John Beiter to charge my credit card account after each office visit for the agreed upon session fee. This authority will remain in effect until I notify Dr. John Beiter in writing otherwise. If I change the credit card specified, I will provide written authorization for the new credit card to Dr. John Beiter immediately.

_____/_____/20____

Signature

Date

NOTE: IF PAYING BY CREDIT CARD YOU WILL BE CHARGED A 5% PROCESSING FEE THAT IS A PASS THROUGH CHARGE