CREDIT CARD GUARANTEE

[ ] SELF-PAY PATIENTS

You are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment fee** of **$125** in the event that you miss an appointment without giving **24-hours' notice**.

I agree to the above terms and authorize you to charge my card.

____ _________________
SIGNATURE DATE

- -

CREDIT CARD: ❒ AMEX ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER'S NAME ____

BILLING ADDRESS ____

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CARD # _____________________________________ EXP. DATE ___________

THREE DIGIT CID NUMBER __________