Credit Card Preauthorization

Krantz Family Chiropractic & Wellness Center
Dr. Michael Krantz
3882 Skippack Pike
Skippack, PA 19474
(610) 222-9555

Patient Name: ____

Dear Patient,
For your convenience you may pay your account balance with your credit card. Please complete the information below:

I authorize the health care provider shown above to charge my credit card account for my balance due for:

- o Past Services
- o This visit only
- o All visits this year
- o Recurring charges for ongoing treatment

$______________ per _______________________
Amount Week or Month

From ______________ to _____________________
Date Date

- o Other ____
- o ____
- o ____
- o ____

Visa VISA MasterCard Accepted **Master Card** Other __________________

Charge Account Number ___________________________ Exp. Date __________ VID# _________

Cardholder Name ____

I understand that this form is valid for one year unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature _______________________________ Date: _____________________