Authorization to Keep Credit/Debit Card Information on File

Sunday, February 18, 2018 10:23 AM

Silberkleit and Associates LLC / Dr. Judith Silberkleit

Your credit card information is kept confidential and secure and payments to your card are processed for therapy copays or unmet insurance deductibles.

I authorize Silberkleit and Associates / Dr. Judith Silberkleit to charge to the following credit or debit card:

Visa _____ Mastercard _____ Discover _____ Amex _____

Credit Card Number _____

Expiration Date Month _____ Day _____ Year _____

Security Code _____

Name as it Appears on Card _____

Signature _____

Billing Address _____

City, State, Zip _____

I/we the undersigned authorize and request Silberkleit and Associates / Dr. Judith Silberkleit to charge my credit card indicated above for balances due for services rendered.

This authorization relates to all payments for services provided

to me by Silberkleit and Associates / Dr. Judith Silberkleit. This authorization remains in effect until I cancel this authorization. To cancel I must give a 30 day notification in writing and the account must be in good standing I understand that any amount owed at the time of cancellation will be charged to the account.

Client Name (Print) _____

Signature of Responsible Party _____

Responsible party name if different from client (print)

_____

Date _____