Credit Card Authorization Form

This is a Credit Card Authorization Agreement
This "agreement" dated on this date:

Between
Client First and Last Name:

AND Ohmni Naturopathic Family Medicine

PLEASE NOTE: ALL BILLING ACCOUNTS ARE REQUIRED TO PROVIDE A CREDIT CARD NUMBER IN FULL

Credit Card

Visa
Master Card
AMEX

Name On Card:

Expiration Date:

Card Number:

Security Code:

Billing Zip Code associated with the card:

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Patient Signature

The credit card above on file will be charged according to the billing preferences. Printed statements are sent out once a month upon request. For billing invoice requests, questions or concerns, please call 707-968-7056.

I CERTIFY THAT I AM FINANCIALLY RESPONSIBLE AND WILL BE HELD ACCOUNTABLE FOR THE ACCOUNT AND AGREED BILLING PREFERENCES LISTED ABOVE. I UNDERSTAND THE BILLING OPTION CHOSEN ABOVE WITH THE CORRESPONDING TERMS AND CONDITIONS WILL BE APPLIED TO ALL TESTS, SERVICES ANAD SUBSCRIPTIONS SUBMITTED.

X

Print name: **Date:**