HEALING JOURNEY
ACUPUNCTURE AND WELLNESS

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Credit Card on File Policy

Our clinic requires your credit or debit card information to be kept on file as a means of payment for missed appointment fees (**$_____ per appointment when you give less than 24 hours notice of cancellation**). By completing this form, you also authorize this card to be used for payment of outstanding treatment fees, or herbs purchased, if applicable. Your credit card information is kept confidential and secure always.

Type of Card:

☐ **American Express** ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Card already on file**

Credit Card Number:

_____

Expiration Date: _____ / _____

Name on card:

_____

Signature:

_____

Billing Address:

_____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, authorize and request the clinic listed above to charge my credit card for balances due that are my financial responsibility.

The authorization relates to all payments for services or merchandise provided to me by the acupuncturist(s) for fees incurred. This authorization will remain in effect until I cancel it via email or letter, and my patient balances are paid in full.

Patient Name (Print):

_____

Patient Signature:

_____

Date: _____ / _____ / _____