**CREDIT CARD CHARGE AUTHORIZATION**

**Purpose:** Authorize Encompass Nutrition LLC to charge payments to a credit card.

**Instructions:** Print or type. Send the completed form with other required documentation to Encompass Nutrition at the above address.

**CUSTOMER INFORMATION**

**Patient Name:**       **BIRTH DATE (mm/dd/yyyy)**

**CREDIT CARD HOLDER INFORMATION**

**Card Holder Name:**       **MAILING ADDRESS**         
**CITY**       **STATE**       **ZIP CODE (required)**       **DAYTIME TELEPHONE NUMBER**

**AUTHORIZATION**

**I authorize Encompass Nutrition LLC to charge the credit card listed below for services issues on or after the patient’s appointment(s) date(s).**

|  |
| --- |
| Account Type:  Visa  MasterCard  AMEX  Discover  Cardholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_  CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) \_\_\_\_\_\_ |

**I understand the following may be charged to my credit card: Copays, Account Balance, No-Show or Late-Cancel Fee**

**CARD HOLDER *SIGNATURE*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_