ZABRECKY
INSTITUTE of Biomedicine

Credit Card Preauthorization

Dear Patient,

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

Patient Name:_____ Date:_____

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

- ❑ Past services
- ❑ This visit only
- ❑ All visits this year
- ❑ Recurring charges for ongoing treatments:
  $_____ per _____
  Amount Week or Month

  from_____ to _____
  Date Date
- ❑ Other_____

  _____

  _____

❑ Mastercard ❑ VISA ❑ American Express

❑ Other_____

Charge Account Number_____Exp. Date_____

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_____

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