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PAYMENT INFORMATION

For your convenience, credit cards are accepted as a form of payment. Your credit card info is also kept in abeyance in case other forms of payment are not made before or at the time of service. Thank you for completing the form below.

Visa MasterCard American Express

Your Name

Billing Name

Card Number

Expiration Date

Security Code

Billing Address

City, State Zip

CREDIT / DEBIT CARD AUTHORIZATION

Purpose: This form is used to register credit card information with Dr. Charlotte Reznick, allowing you to pay for services rendered. Your credit card information will be kept secured and confidential.

By submitting this form, the undersigned agrees to the following:

1. I hereby authorize Dr. Charlotte Reznick to make charges upon the credit card for any applicable fees for services I receive.
2. I understand that this form will be kept on file and will remain in effect until revoked in writing and/or the expiration date of the card has passed. I understand that it is my responsibility to complete a new credit card authorization form when the credit card has been renewed, revoked, cancelled or misplaced.
3. I understand that in the event any charge against this account is denied, I will be notified immediately to make payment in cash, money order, Venmo, or certified check for any outstanding balance.
4. I understand that this authorization will be ended after treatment is terminated.

Signature

Print Name

Date