

## CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

### A. PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

### B. CARD INFORMATION

Name as it Appears on Credit/Debit Card  
\_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

CARD NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
CCV Code

### C. CREDIT/DEBIT CARD AUTHORIZATION

I authorize Epic Wellness or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of each single visit charged for services & treatment that is received.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Please note: Your card billing date may not occur on your treatment date due to insurance processing times. Your charge may be up to 30 days delayed. Please contact us for further details.***

### D. RECEIPT

**Please Select One:**

No receipt needed

Yes, please email me a receipt at \_\_\_\_\_