EPIC PERFORMANCE

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 _____

SUBMIT PRINT

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