Credit/Debit Card Payment Consent Form

Payee Name ____
Print Last *First* *Middle Initial*

Name on card if different ____

I authorize Chesapeake South Therapeutic Group LLC **to charge my card for professional**

payment as follows:

* All deductible costs not covered by your insurance company

* Any missed appointment, not cancelled within 24 hours, will result in a $45.00 charge

* Any outstanding bill for services rendered

This credit card will be charged following services rendered. It is my responsibly to confirm copayment and deductible amounts per my insurance plan.

Type of card: VISA __ MASTERCARD __ AMEX __ DISCOVER __

Card Number: _________ - _________ - __________ - __________

Expiration Date: _____ / _____ **Security Number** (on back of card)**:** _______

Card holder's billing address:

____
Street/apt/floor *City* *State* *Zip Code*

Valid Email for Receipts: ____

Card holder's signature: _________________________________ **Date:** ___ / ___ /____