



Lifestyle Wellness Center

Family & Sports Chiropractic

Credit Card Authorization Form

Please complete all the fields below.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Lifestyle Wellness Center to charge my credit card above for the \$20 cancellation fee for any missed appointments without a 24 hour notice.

We also will use this card to charge any outstanding balances. We will notify you before we charge your card. I understand that my information will be saved on file for future transactions on my account.

Signature

Date