

## CREDIT CARD PREAUTHORIZATION

**LIFE EXTENSION CENTER**  
425 Main Street  
Ridgefield, Connecticut 06877  
Phone (203) 431-6165  
Fax (203) 431-6167

**LIFE EXTENSION CENTER**  
2505 Boulevard of the Generals  
Norristown, Pennsylvania 19403  
Phone (203) 431-6165  
Fax (203) 431-6167

Dear Patient,

For your convenience, you may pay your account balance with your credit card. Please complete the information below:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the health care provider shown above to charge my credit card account for my balance due for:

- Past services  
 This visit only  
 All visits this year  
 Recurring charges for ongoing treatments:  
\$ \_\_\_\_\_ per \_\_\_\_\_  
Amount Week or Month

from \_\_\_\_\_ to \_\_\_\_\_  
Date Date

- Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

 Mastercard

 VISA

Other \_\_\_\_\_

Charge Account Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

Cardholder Name \_\_\_\_\_

I understand that this form is valid for one year unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature \_\_\_\_\_