

CREDIT CARD PREAUTHORIZATION

LIFE EXTENSION CENTER

425 Main Street
Ridgefield, Connecticut 06877
Phone (203) 431-6165

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 _____