**HEALTHY HABITS WELLNESS CLINIC, INC.**

**Credit Card Payment Authorization Form**

***Select a Payment Option:***

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Healthy Habits Wellness Clinic (HHWC) to charge my credit/debit card indicated below for a one-time payment in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ according to the Service Agreement for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Patient).
* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Healthy Habits Wellness Clinic (HHWC) to charge my credit/debit card indicated below in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_ according to the payment plan shown on the Service Agreement and/or Automatic Debit Authorization form for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Patient).

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| **Cardholder Information:** |
| **Cardholder Name:** | **Phone:** |
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| **Billing Address:** | **City, State, Zip:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Card Number:** | **Expiration Date:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Email Address:** | **CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX):** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |
| **Card Type:** |  |

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**CONSULTANT SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above and I agree to the terms on the Service Agreement as the responsible financial party for the Patient named on the Service Agreement with HHWC. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the last business day before the holiday. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 60 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I understand that if my credit card declines on a scheduled payment date, then I will be charged $10.00 per day until the schedule payment due is made. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.