Credit Card Authorization

Please complete this form if you would like New Smyrna Wellness to keep your credit card/debit card on file for future payments (co-pays, etc). You may elect to provide us with credit card information separately for each payment.

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

Card Type: *(circle)* Visa MasterCard American Express Discover Care Credit

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Account name(s), if different than cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize New Smyrna Wellness Center (MDPA Solutions, Inc) to charge the above credit card account for payments owed to my/patient’s account for services rendered at their office (co-pays/co-insurance/etc). I will be told my co-pay/charges prior to the payment. I may elect to discontinue or withdraw this authorization at any time, either verbally or in writing. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

This card will only be charged with authorization for services rendered.

Cardholder Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_