PRE-AUTHORIZED PAYMENT FORM

I authorize Dr. Timothy Lee
(Provider name)
to keep my signature on file and charge my credit card and/or debit card for:

I agree that my credit/ debit card listed below may be automatically charged
$_____ for every _____ minutes of appointment time.
_____(Initial) Expires on:_____

I agree that my credit card/debit card listed below may be automatically charged
$ 75.00 for each session not cancelled within 24 hours or for each missed appointment..
(Exceptions will be made if approved by my provider**.)** **_____(Initial)**

I agree that my credit/debit card may be automatically charged for any amount due either by me or my insurance company past due over 90 days. **_____(Initial)**

****I UNDERSTAND THAT I MAY REVOKE THIS AGREEMENT AT ANY TIME BY PROVIDING A REQUEST IN WRITING.**

Client's name _____

Cardholder's name _____

Cardholder's address _____

City _____State _____ ZIP _____

_____ Visa _____MasterCard _____Discover Card

Account number _____

3 Digit Verification Code_____Expiration Date _____

Signature _____Date_____

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