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**Credit Card Payment Authorization**

I, (print name) \_\_\_\_\_ authorize New Life Homeopathy, Inc. located at 1415 Beacon Street, Suite 220, Brookline, MA to bill my credit card for services rendered in the office, over the internet, or by phone.

This authorization may be revoked at any time when the following stipulations have been performed:

- 1- Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
- 2- Patient's account is paid in full

Exact name on credit card: \_\_\_\_\_

Credit card holder's billing address where the statement is mailed:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Visa card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Master card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Last 3 digits on back of card: \_\_\_\_\_

Card holder's signature: \_\_\_\_\_

Today's date: \_\_\_\_\_