Client Last Name:_________________

This is Card # on File: 1 ☐ 2 ☐

CREDIT CARD AUTHORIZATION FORM

TMG uses a secure electronic health record (EHR) payment system. Your provider will enter your credit card information into this system with your permission and charge your account through it.

By signing below I authorize TMG to use the credit card information below to charge my credit card using an on-line system for the following purposes:

1) **FOR EACH SERVICE AT THE TIME OF SERVICE** provided to me by a service provider of TMG.
2) **FOR A MISSED APPOINTMENT** at the rate of $85 if I cancel less than 24 hours in advance of my appointment.
3) IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE. My service provider will inform me about this charge.

I acknowledge that I will be receiving an email with a receipt for the payment, as well as an e-mail with an itemized statement with appropriate information needed to submit to my insurance company and/or for tax purposes.

Provider(s) being seen at TMG: ____

PLEASE COMPLETE

Credit Card Type: ___ MasterCard ___ Visa ___ American Express ___Discover

Credit Card # ____

Exp. Date _________ Security Code ________

Credit Card Holder’s Name on Card ____

Email Address for Receipts ____

ZIP Code for this account:____

Signature______________________________________Date:_______________________