**Credit Card Authorization Form**

Please complete all fields. Credit cards are held on file in the event of a no-show or late cancellation. Cancellations with less than 24 hours notice or not showing up for your scheduled appointment will result in being charged the full amount of your appointment fee.

**Credit Card Information**

**Card Type** \_\_\_\_\_MasterCard \_\_\_\_\_Visa \_\_\_\_\_Discover \_\_\_\_\_AmEx \_\_\_\_\_HSA

**Cardholder Name (as shown on card**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Expiration Date (mm/yyyy**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CVV Code**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardholder ZIP Code (from credit card billing address**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Frederick Health and Well**ness to charge my credit card above for agreed upon services. I understand that my information will be kept on file for future transactions on my account.