CREDIT CARD AUTHORIZATION FORM

Please complete all sections. If you need to cancel this authorization, please contact us within twenty-four hours of mailing this form. We may not be able to cancel this authorization once this form is received and processed.

Credit Card Information
Card Type: ○ MasterCard ○ Visa ○ Discover ○ AMEX
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): CVV:
Cardholder Zip Code (from credit card billing statement):
Patient Name (if different from cardholder name):
Amount to be charged:

I authorize Williams Chiropractic to charge my credit card in the amount listed above to be charged immediately upon receiving this authorization.

_____ _____

Cardholder Signature Date

Please mail to:

Williams Chiropractic
14101 S. MurLen Rd.
Olathe, KS 66062