CREDIT CARD AUTHORIZATION

I, (print name) _____ authorize my credit card for any services rendered as agreed to. I also authorize Shelby Castile to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance.

I further authorize Shelby Castile to disclose information about my attendance/ cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type:
Card #:
Name on Card:
Billing Address (Street, City, State & Zip):

Expiration Date:
CVV: (last 3 numbers on back of card)

Signature:_____ Date:_____

*Cancellations must be made at least 24 hours in advance or fee must be paid in full and I am aware there is a $25.00 fee for declined credit cards.

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, without payment rendered.