

Credit Card Authorization Form

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN IT TO US IF YOU
WOULD LIKE US TO KEEP YOUR CREDIT CARD ON FILE.
All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

Billing Phone: _____ Cell Phone: _____

Email address: _____

Credit Card Type: _____ Visa _____ MasterCard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit
card): _____

I authorize **Glenn Frieder Chiropractic** to charge chiropractic services,
supplements, and any additional supply fees to my credit card provided herein
for me and/or family members listed below:

Name: _____ Name: _____ Name: _____

I agree that I will pay for these purchases in accordance with the issuing bank
cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Dated: _____

Name: _____

**Will you need statements to submit to your insurance provider? If so, we can
mail them to you for your convenience. _____ YES _____ NO