**CREDIT CARD AUTHORIZATION AGREEMENT**

**Frauke C. Schaefer, MD, Inc.**

**Patient Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Credit Card Type: Visa Mastercard Other \_\_\_\_\_\_\_\_\_\_\_\_(I do not accept American Express)

Card Holder’s name as shown on credit card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/YY)

Three Digit Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Credit Card Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email of Credit Card Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I hereby authorize Frauke C. Schaefer, MD, Inc. to charge the credit card above to collect the patient portion of payments due for services rendered. An account invoice can be requested and will serve as receipt for payments.

 I also authorize Frauke C. Schaefer, MD, Inc. to charge the credit card for applicable fees such as fees for prescriptions that need to be called in at my request outside of office visits (rather than by electronic prescriptions), and any fees for sessions missed or cancelled after the 24-hour limit, unless other arrangements have been made.

 I understand that I am responsible to update payment information as necessary. If Frauke C. Schaefer, MD, Inc. is unable to process my payment, I will be responsible for an alternate payment arrangement.

 I understand that this agreement shall remain unless I cancel it in writing (e-mail is sufficient). I will not dispute Frauke C. Schaefer, MD, Inc.’s charges to my credit card as long as the amount in question is for services already rendered as well as related applicable fees. I guarantee that I am the legal cardholder for this credit card and legally authorized to enter into this agreement with Frauke C. Schaefer, MD, Inc. I acknowledge that I have read and agree to all the above terms and conditions.

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Signature of Credit Card Holder (Required) Date