Long Chiropractic Center
Payment Authorization Form

Please complete all fields.

Credit Card Information: PLEASE CIRCLE

Visa Mastercard Discover Amex Other: ____________________

Card Holder Name: ____
Card Number: ____
Expiration Date: _________________________________
Security Code: _________________________________
Card Holder Zip: _________________________________

ACH Debits/Bank account information: PLEASE CIRCLE

Checking Savings

Bank Name: ____ Branch: ___________________
City: ____________________________________ State: _________ Zip: __________________
Routing Number: ______________________________
Account Number: ______________________________

If ACH Transactions are rejected for Non Sufficient Funds (NSF) I understand that Long Chiropractic Center may at its discretion attempt to process the charge again within 30 days, and agree to any additional $40 charges for each attempt returned NSF which will be initiated as a separate transaction.

I, __________________________________ authorize Long Chiropractic Center to charge my credit card above for agreed upon services. I understand that my information will be stored for future transactions on my account. I understand that this card/bank account will be charged my patient responsibility as indicated on the patient's ledger and also in accordance with the late cancellation/no show policy. **This authorization will remain in full force and effect until Long Chiropractic has received written notification from me of its termination in such time and in such a manner as to afford Long Chiropractic Center a reasonable opportunity to act on it.** I acknowledge that the origination of ACH transactions to my account must comply with the provisions of US law.

____ ______________________
Customer Signature Date

For office use only:

Date terminated: