Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Sleep Innovations PLLC to charge my credit card above for agreed upon office visits after visit has processed with insurance. Any balance due after insurance has processed will be charged to the credit card on file. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date