BELLA VITA
INTEGRATED HEALING

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CREDIT CARD AUTHORIZATION

Our Automatic Payment Policy: You are authorizing scheduled charges to your credit or debit card. You will be charged at the time of your visit. If you cancel an appointment without 24-hour's notice, or if you do not show for an appointment, you will be charged the full session fee. A receipt and itemized invoice can be emailed to you, if requested. If your card is declined, or payment is not received, this may delay medications being filled and prevent the ability to schedule future appointments. By signing this form, you agree that no prior notification will be provided when your standard fee is charged for a session, no-show, or late cancellation. You care will never be charged for payments outside of the scope of this agreement, without prior notification and your consent.

Patient Full Name: _____

Card Holder's Name (if different from above): _____

I _____ (Full Name) authorize Bella Vita Integrated Healing, PLLC, to charge my credit or debit card at the time service is received, or per the office poilcy regarding late cancellation and missed appointments.

Credit/Debit Card Number:_____**Exp Date:**_____**CVV:**_____

Billing Adderss:_____

State:_____**Zip Code:**_____**Phone:**_____

Email (Invoices will be sent here):_____

For any billing questions, please call/text 602-671-3091 or email E_ShraderDNP@protonmail.com

I authorize the above-named business to charge the credit/debit care indicated on this authorization form according to the terms above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing. I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company, provided the transactions correspond to the terms indicated on this authorization form.

Patient Signature: _____ **Date:**_____