Lifetime Insight, LLC
440 Regency Parkway Dr., Suite 136
Omaha, NE 68114
Office: 402-934-7404
Fax: 402-909-0196

CREDIT CARD AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I understand that appointments will not be scheduled until all forms have been read, completed, and signed, and a credit card is on file to secure appointment times. The card provided will not be used for the appointments, sessions, and services unless they are overdue by more than 30 days, or for other reasons as stated in the Office Policies and Procedures. I understand that this card will be charged for no-show or late cancel appointments at the fee stated in the Office Policy and Procedures, that I have read and agreed to abide by.

I hereby authorize Lifetime Insight, LLC/Sarit Hovav, MD, to charge the following described Credit Card and have been duly informed of the Policies and Procedures as they were outlined to me in the Office Policies and Procedures form and above. I am hereby aware of the treatment and charges and agree to assume financial responsibility. I understand that this form is valid until I provide written notice that it is revoked. I also understand that if I change credit cards, I will supply Lifetime Insight the new credit card information. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in the Offices Policies and Procedures form. I further authorize Lifetime Insight, LLC to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (check one): ☐ Visa ☐ Mastercard ☐ AmEx ☐ Discover

Card Number:	Expiration Date: (_____ /_____)
Cardholder Name:	CID (last 3 on back):
Billing address: Billing City, State, Zip:	

Patient/Cardholder Signature: _____

Financially Responsible Party (if cardholder different than patient):_____

Date: _____