



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 the appointment time. The card provided will be used for the appointments, sessions, and services. I understand that this card will not be charge unless I no-show or late cancel, or for other reasons as stated in the Office Policies 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. 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: _____