Glenview Healing Arts Center

Credit Card Authorization & Cancellation Policy

I clearly understand and agree that all services rendered to me, including appointments cancelled within 48 hours notice, are charged directly to me and I am personally responsible for payment. I also understand that fees for professional services, products and shipping charges rendered to me will be immediately due and payable. If there is any unpaid balance on my account at any time, it will be charged to my credit card if no other payment arrangements have been agreed upon.

Authorization to debit or credit card:

Patients name: ______________________________

Cardholder's Name: ______________________________

☐ Visa ☐ MasterCard

16 Digit Credit Card Number: ______________________________

Expiration Date (MM/YY): ______________ Security Code: ______________

Billing Address (street # only): ______________ Billing Zip Code: ______________

Please bill charges I incur to the card listed above for services, supplies and shipping. I understand written notification of the dates of service and itemized charges will be sent to me for my records.

I have read and understand the above.

Signature: ______________________ Date: ______________________