CHARGE TO BE DONE

Patient
Name:_____Clinician:_____

Account #:_____

Visa M/C Discover:_____-_____-_____-_____ Exp Date:_____/_____

Cardholder Zip Code:_____(if we don't have, we cannot run charge)

V-number(important):_____(located on back of card by signature)

Minimum charge: $ 15.00
Amount to be charged & Date: $_____-____/____/___ $_____-____/____/___**over→**

Receipt: □Give to Therapist □Mail:Client/Cardholder (include address)

Cardholder Name(if different than above):_____

Signature_____
By signing this form it authorizes Perakis, Resis Woods & Associates to charge my credit card and keep my signature on file for future charges as authorized by me.
If receptionist is here, send patient to Check Out. All charges/cards must be run thru machine.

$_____-____/____/__	$_____-____/____/__	$_____-____/____/___
$_____-____/____/__	$_____-____/____/__	$_____-____/____/___
$_____-____/____/__	$_____-____/____/__	$_____-____/____/___
$_____-____/____/__	$_____-____/____/__	$_____-____/____/___
$_____-____/____/__	$_____-____/____/__	$_____-____/____/___
$_____-____/____/__	$_____-____/____/__	$_____-____/____/____
$_____-____/____/__	$_____-____/____/__	$_____-____/____/____
$_____-____/____/__	$_____-____/____/__	$_____-____/____/____
$_____-____/____/__	$_____-____/____/__	$_____-____/____/____