BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

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Credit Card Payment Authorization Form

Sign and complete this form to authorize Bassi Clinic, to keep your credit card on file for payments.

Please complete the information below:

I _____ authorize Bassi Clinic, to keep my credit card
(Patient Name)
account indicated below, on file, for payment of any charges, including but not limited to copayments, that are due for medical services, provided by this clinic.

Billing Address: _____

Phone# _____ Email _____

Account Type: ☐Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name_____

Account Number _____

Expiration Date _____

Patient Name: _____

SIGNATURE _____ DATE _____

I authorize the Bassi Clinic, to charge the credit card indicated in this authorization form according to the terms outlined above. 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 this form.