45 Manor Hill Suite 100
Canfield, OH 44406
330-702-3937

Credit Card Authorization Letter

Please complete this form with a legible copy of both:
(1)Front and Back of Credit Card
(2) Current picture I.D. (i.e. Driver's License, passport, military ID)
Note: Both items must identify the same person and signature

I_____, hereby authorize Dr. Betsy Ahlquist, O.D. and her office staff to charge my credit card for outstanding balances due for vision services rendered for myself and my children at her Optometric office.

Please list all persons under your account:

_____

_____

Name of Account/Card Holder (exactly as it appears on credit card)

_____

Type of Credit Card (please check one):
( ) VISA ( ) MASTERCARD ( ) CARECREDIT ( ) DISCOVER ( ) AMERICAN EXPRESS
Is this a debit card? _____Yes_____No
Disclaimer: Our office is not responsible for any overdraft or fees that may be applied to your bank account if insufficient funds occur

Credit Card Number_____
Expiration Date_____ CVV Code: _____

Card Holder's Billing Address (exactly as it appears in the credit card billing statement)

_____
_____

I acknowledge that my liability for these charges will not be waived and that I will be held personally liable in the event that the issuing institution refuses to pay the full amount due. I hereby certify that the credit card information above is accurate, up to date and is my credit card.

Cardholder's
Signature: _____ Date: _____
Contact Telephone Numbers:
Home: _____
Work: _____
Cell: _____