Credit Card Authorization Form

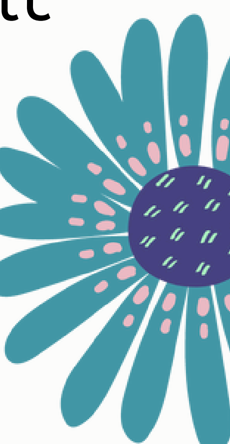
Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until cancelled. This information will be processed by Square, Inc. and may be stored in the United States and other countries.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ___________________________
Cardholder Name (as shown on card): ___________________________
Last 4 digits of Card Number: ___________________________
Expiration Date (mm/yy): ___________________________
Cardholder Postal Code (from credit card billing address): ___________________________

I, ______________________ authorize

Grow Family Health / Prisma Health Care Collaborative to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

I understand the late/no show policies of Prisma Health Care Collaborative, its providers and groups/individuals operating within. I understand and agree to have the card on file charged for the amount outlined according to the policies, in the event that I or my dependents incur charges as a result of these policies.



Client/Patient Signature ______________________ **Date** ______________________