Client/Guarantor Credit Card Pre-Authorization

CLIENT NAME	D.O.B.	Parent/Guardian Name (if under 18)
Phone #	Email	Physical Address
AUTHORIZED PAYER	Position	Organization
Phone # Fax #	Email	Mailing Address

Payment Options

_____ (initial) I hereby authorize The Wellness Centre to charge the balance of my account automatically each month. Card will be charged the FIRST of each month for prior month fees.

_____ (initial) I hereby authorize The Wellness Centre to charge the portion of services my insurance does not cover at the time of determination.

_____ (initial) I choose to manually pay my account balance. After 30 days, account balances will automatically be charged to the card on file.

_____	_____	_____
SIGNATURE	Print Name	Date (DD/MM/YY)

On behalf of the Authorized Payer

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CREDIT CARD AUTHORIZATION

NAME ON CARD:_____

CARD NUMBER:_____

EXPIRATION DATE:_____ SECURITY CODE: _____

_____	_____	_____
CARD HOLDER SIGNATURE	Print Name	Date (DD/MM/YY)

On behalf of the Authorized Payer