Healthy Foundations Group
A Team Approach to Superior Care.

4350 East-West Highway
Suite 200
Bethesda, MD 20814

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FX: 888.715.1130
HEALTHYFOUNDATIONSGROUP.COM

Credit Card Authorization Form

The card will be charged in accordance with our office and cancellation policies.

Today's date_____/_____/_____ Patient Name: _____

Credit Card Information

Name as it appears on the Card:

_____

Type of Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Credit Card Number_____ Expiration Date____/_____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address: Street: _____

City: _____ State:_____ Zip Code: _____

Telephone: _____

****I hereby authorize this card to be used for payment of services rendered.**

Cardholder's Signature:_____ Date: _____/_____/_____

☐ I hereby authorize this card to be used for payment of future services rendered (please sign again for future authorization):

Cardholder's Signature:_____ Date: _____/_____/_____

This Authorization can be faxed to 888-715-1130 or mailed to the address above