Kari Lenox, Ph.D.

Kari@karilenox.com
Phone: (919) 237-2250
Fax: (919) 251-9660

CREDIT CARD AUTHORIZATION

DATE :	**PATIENT NAME:**	**OFFICE ACCOUNT NO.:**

CREDIT CARD AUTHORIZATION

Credit Card Holder's Name:
(Please print as it appears on the card)

MAILING ADDRESS WHERE CREDIT CARD STATEMENT IS SENT:

Street Address: City: State: Zip Code:

Home Phone: Email:

_____Initial ***I hereby authorize charges to my credit card for services rendered by Dr. Kari Lenox, Ph.D. that are not paid directly in cash or check.***
_____Initial ***I understand that late or non-cancelled (no show) visits will be charged to my credit card.***
_____Initial ***I understand that it is my responsibility to notify office personnel if I change my credit card companies and/or numbers.***
_____Initial ***I will update the expiration date of my credit card when necessary.***

CREDIT CARD INFORMATION

Credit Card Company:
□ Visa □ Master Card □ Other _____

Credit Card Number:
_____ - _____ - _____- _____

Credit Card Three Digit Security (CCV#):
_____

Expiration Date:
_____ / _____

Signature: Date: