Synergique Healing, PA

Behavioral Health & Functional Medicine

Credit Card Authorization

I,_____, am authorizing Synergique Healing, PA to charge my card listed below if I fail to show, cancel or reschedule an appointment late.

I am aware I need to provide notification at least 48 business hours (2 business days) in advance.

I am aware that reminder calls, texts and emails are a courtesy. I am responsible for my own appointment regardless if a reminder was received or not.

I further authorize Synergique Healing, PA, to disclose information about my attendance or cancellation to my card company if I dispute a charge.

Credit/Debit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit/Debit Card Number:_____

Expiration Date:_____ **CVV Security Code**:_____

Full Name on Card:_____

Complete Billing Address :_____

City, State, Zip code:_____

By signing below I acknowledge that I read and understand the above terms and consent for Synergique Healing, PA to place and keep my card information in my patient file. I understand my card will be charged the applicable fees in the events I do not show to my appointment or I cancel/reschedule within the 48 business hours of my appointment or at my request for other services..

Signature:_____ Date:_____
Name and relationship to Patients (If differ.):_____
If signed electronically*, **Date of Birth of signer:_____ **Phone#**:_____

Witness Name: _____ Witness Signature: _____

**This form will be securely stored in your clinical file and may be updated upon request at any time.*

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