Credit Card Authorization

Dr. Vivian Sierra, LLC provides secured methods of accepting your payment at the time of service and for keeping your credit card on file.

I, (Card Holder) _____ , authorize Dr. Vivian Sierra, LLC to maintain my credit card information and signature on file for charges, including copayments, deductibles, or coinsurance responsibilities, late cancellation fee charges as determined, and any outstanding balances for services unpaid after sixty (60) days.

Client Name: _____

Card Holder Name: _____

Type of Credit Card:

Mastercard Visa Amercan Express Other _____

Credit Card #: _____ Billing Zip Code: _____

Expiration Date: ___/___ Security Code: _____

Card Holder Signature: _____

Date: ___/___/___