

Credit Card Authorization Form

MADEIRA CHIROPRACTIC AND REHABILITATION

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Please complete all fields. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (<i>as appears on card</i>): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (<i>from credit card billing address</i>): _____

I, _____, authorize **Madeira Chiropractic and Rehab** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Patient Signature

Date