Kelly Knickerbocker, ARNP, PLLC

Credit Card Agreement

Patient Name:________________________________ **DOB:**__________________

Credit Card on File:
It is our policy to keep a credit card on file to pay for services. We keep a patient's information secure to ensure its safety.

Telehealth: Kelly Marie, ARNP, PLLC meets with most patients via telehealth. Once your appointment is complete we will notify you, via text, how much you will be billed.

By signing below, I authorize Kelly Marie, ARNP, PLLC to keep my signature and my credit/debit card information securely on-file in my account. I authorize Kelly Marie, ARNP, PLLC to charge my credit card for any outstanding balances when due.

Patient Name(print): ____
DOB:________________________
Name on Card:____
Credit Card #:____
Exp Date:________________________ Security Code:________________

Please fill out the information below for any other person(s) you authorize this credit card for:

Patient Full Name (print):____ DOB:_________
Patient Full Name (print):____ DOB:_________
Patient Full Name (print):____ DOB:_________
Patient Full Name (print):____ DOB:_________

Card Holder's Signature: ____ Date: _________