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CREDIT CARD GUARANTEE OF PAYMENT

I understand that I ultimately bear full responsibility for all reasonable and customary fees for rendered services.

With this form, I am granting authorization to charge my credit card for any outstanding invoices that have not been paid within 7 days of the date of service. If reimbursement has not been received within 3 days of the service date, I will be notified of the outstanding balance and encouraged to send payment and/or resolve the situation. If payment has still not been received within 3 days of notification, my credit card will be billed for the full outstanding balance (+ 3.5% merchant fee).

With this form, I am also granting Dr. Juni permission to charge my credit card at the rate of \$250 per scheduled hour (+ 3.5% merchant fee) for late arrivals greater than 15 minutes as well as for any missed or cancelled appointments with less than 48-hours advance notice.

I understand that this form is valid for three years from the undersigned date, unless notification of revocation is received in writing.

Client's Name:	
Cardholder name (if different than client):	
Full Billing Address:	
Type of Credit Card:	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Credit Card Number	
Expiration Date	
CV#	

Cardholder Signature: _____

Date: _____