Credit/Debit Card Authorization

I, _________________________________, authorize Barnes & Klatt, P.C. to keep my signature on file and to utilize this credit card information to pay for any services rendered to/or outstanding balances due for patient__________________________.

I understand this authorization is valid until I cancel through written notice to the health care provider or unless otherwise indicated._______ (initials)

Visa_____ Mastercard _____ Discover_____ Credit_____ Debit_____

Card Member Name:______________________________________

Credit Card Number: ______________________________________

Exp. Date:_____________________

Security Code:________________

Zip Code:_____________________

Is this a Flex spending/health reimbursement account card? Yes____ No_____

____

Card Member Signature Date

Barnes & Klatt P.C.
1660 Feehanville Drive, Suite 400
Mount Prospect, Illinois 60056