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_____ Amex____

Debit_____ Credit_____

Card Member Name: _____

Credit Card Number: _____

Exp. Date: _____

Security Code: _____

Home Street Number: _____

Home 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