VIC Credit Card Storage Authorization Form

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Purpose of Authorization

By completing this form, you authorize Valley Integrative Chiropractic to securely store your credit card information and charge your card for services provided, including but not limited to chiropractic adjustments, nutrition consultations, neuroemotional adjustments, and other services rendered as well as product purchase.

**CREDIT CARD INFORMATION

Cardholder Name (as it appears on the card):

Credit Card Type:

- ☐ Visa
- ☐ MasterCard
- ☐ American Express
- ☐ Discover

Last 4 Digits of Credit Card Number:

Expiration Date (MM/YY):

Billing Zip Code:

Authorization Terms

By signing below, you acknowledge and agree to the following:

I authorize Valley Integrative Chiropractic to securely store my credit card information within their Electronic Health Record (EHR) system for billing purposes.

I authorize charges to my credit card for services rendered, including missed appointments or late cancellation fees, as per the practice's cancellation policy.

I understand that this information will be securely stored in compliance with HIPAA and PCI-DSS (Payment Card Industry Data Security Standard) regulations to protect my privacy.

I acknowledge that I can revoke this authorization at any time by providing written notice, effective after any outstanding balances are settled.

I understand that if my card information changes, it is my responsibility to provide updated information to avoid interruption of services.

Client Signature or Cardholder's Signature (if different from the Client)
By signing this form, you confirm that you have read and understand the terms outlined above and agree to the use of your credit card for billing purposes.

X

Print name: **Date:**