I ______________,understand that it policy of Breakthrough Medicine to keep a credit card on file for missed appointments, payment for telemedicine/phone appointments, or to pay for medication or Supplements. It is my responsibility to update credit card information. I also understand the payment is due at time of visit.

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: ______________________________

Billing Address: ______________________________

____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: ______________________________

Expiration Date: ______________________________

Card Identification Number: ______ (last 3 digits located on the back of the credit card)

Signature____ Date:___________