CREDIT CARD AUTHORIZATION

Credit card type:

☐ Visa

☐ Mastercard

☐ Please check here if card is a debit card

_____________________________ _____________________

Credit card number Security Code / CVV

_____________________________ _____/_____

Name on card Expiration date

____

Mailing address for card (Street, City, State, Zip Code)

_____ I understand that it is the policy of Restoration Health, LLC that payment in full is due at time of service.

_____ Should I choose to pay by check, and my check is returned due to insufficient funds, I understand that my credit card will be charged for the amount due plus any fees incurred by Restoration Health, LLC.

_____ Please provide at least 24-hour's notice should you need to cancel or change an appointment. Restoration Health, LLC reserves the right to charge your credit card for the full amount for all missed, canceled or re-scheduled appointments within 24-hours of the scheduled appointment.

I have read and agree to the terms above.

_______________________________________ __________________________

Cardholder Name (Print) Patient Name (Print)

_______________________________________ __________________________

Signature of Cardholder or Patient Representative Date

____

Relation to Patient

Restoration Health, LLC
477 Route 10 at College Plaza
Suite 206
Randolph, NJ 07869
973.939.3868