



PERMISSION TO CHARGE

www.drweightcontrol.com

716 Lincoln Square
Arlington, TX 76011
817-277-3469

Please print

Patient's Name: _____ Date of Birth: _____

has my permission to charge their office expenses with the Physician's Weight Control and Wellness to my:

☐ Credit Card ☐ Flex / HSA Card

Card Holder - a copy of your picture ID must be attached to this completed form.

Credit Card

Name on Credit Card _____ Billing ZIP Code _____

Relationship to Patient _____

Card Holder's day phone _____ Cell phone: _____

Type of card _____ Expiration date _____

CARD NUMBER: _____ Card Security Code _____

Flex / HSA Card Owner

Name on Flex / HSA Card _____ ZIP Code _____

Relationship to Patient _____

Card Holder's day phone _____ Cell phone: _____

Type of card _____ Expiration date _____

CARD NUMBER: _____ Card Security Code _____

I authorize Physician's Weight Control and Wellness to use my personal credit card or Flex card with the number above to pay charges and expenses for _____.

Patient's name

I understand my credit card information will remain on file electronically & indefinitely until I notify Physician's Weight Control and Wellness to no longer charge services to my card. _____.

Please initial

I authorize use of my card for New Patient cost of \$295.00

☐ YES ☐ NO

I authorize monthly office visit charges of \$120.00

☐ YES ☐ NO

I authorize payment of patient's No-Show Fee (\$25.00 per No-Show)

☐ YES ☐ NO

I authorize payment of patient's CPL lab charges of \$90.00

☐ YES ☐ NO

I authorize one-time transaction for \$_____ on ____/____/____

☐ YES ☐ NO

Card Holder - If for any reason you should dispute any charges from Physician's Weight Control and Wellness you will need to contact the patient and the patient will contact us personally to dispute any charges to your account. Any chargeback or retrieval fee will be forwarded to the above patient.

Signature of card holder: _____

NAME: _____ **DATE:** _____

NOTICE: You have chosen to communicate patient identifiable information electronically; you are consenting to associated risks. We cannot guarantee that information transmitted will remain confidential. In the event of a data breach the above patient will be notified.