



SUNRISE
FUNCTIONAL MEDICINE

Credit Card Authorization

I, (print name) _____ authorize
Sunrise Medical to bill my credit card as shown below for services rendered.

Name on Credit Card _____

Credit Card Details (please print clearly)

Card Type: _____ Visa _____ MasterCard _____ Amex _____ Discover

Card # _____ Exp date: _____

CVV Code: _____

Zip Code where billing statement is received: _____

Card Holder Information—billing address

Name: _____

Address: _____ - _____

City: _____ State: _____ Zip: _____

Phone (include area code): _____

Patient's Name (authorized for charges) _____

Authorization

Card Holder's Signature

Today's Date

Patient's Signature

Today's Date

This authorization may be revoked at any time when the following stipulations have been met.

1. Patient has made a new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.