Dr Cynthia Edwards-Hawver and Associates
411 Davis Street
Clarks Summit, PA. 18411

CREDIT /DEBIT CARD AUTHORIZATION FORM

This is a standard form that is now required for most office practices due to the high rates of deductibles and copayments not covered by insurance. We cannot accept you as a patient into the practice unless this credit card form is completed.

All information you provide will be kept strictly confidential. Your credit card/ debit card will only be used for any unpaid appointment fees (including copayments and deductibles), no show fees, late cancellations, office fees for extended time required between scheduled sessions, and account balances that are past due.

This card will remain on file until your treatment with Dr. Cynthia Edwards-Hawver and Associates terminates. Please note that if the credit/debit card is not active and we are not able to charge for these fees, we will send you a letter indicating your balance. If the balance is not paid in full within two weeks of receiving the letter, we will turn your outstanding bill over to collections unless you notify us of a payment plan.

Full Name (As It Appears On Credit Card): _____

Billing Address

Street _____

City _____

State _____

Zip _____

Card Number Type VISA MASTERCARD AMERICAN EXPRESS OTHER:

Card Number _____

Expiration Date _____ 3 Digit Security Code (On Back of Card) _____

By Signing this form, I authorize Dr. Cynthia Edwards-Hawver and Associates, LLC.
to charge my credit card/debit card for all unpaid appointment fees (including copayments and deductibles), no show fees, late cancellations, office fees for extended time required between scheduled sessions, and account balances that are past due.

Signature of Card Holder _____ Date _____