FAL RIVER HEALTH CENTER, LLC

Integrative Medicine

Linda S. Grigel MHP, PA-C

CREDIT CARD AUTHORIZATION

I authorize Fal River Health Center, LLC to charge the agreed amount listed below to my credit card provider. I agree to pay for these purchases in full in accordance with the issuing bank cardholder agreement. Communication through calls is based on time needed for the response. My credit card will be charged accordingly.

I understand it is my responsibility to provide updated credit card and Health Savings Account (HSA) information (account number, expiration, CSV) as needed. If an HSA is the primary card, an additional credit card will be required to charge for any remaining balance in the event of insufficient funds. Should the HSA or credit card be declined, a three (3) day grace period will be given prior to using the card a second time. If it is declined again, a $25 service fee will be added to the account balance.

I consent to payment being charged and/or withdrawn from my credit card.

Patient Name: _____ Phone: (_____) _____

CREDIT CARD

Full Name on Credit Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Account Number: _____ Expiration MM/YY: _____ CSV Code: _____

By signing this Credit Card Authorization Form, I agree to allow my credit card to be charged as stated above and I attest that the information I have provided is accurate and truthful.

Cardholder Signature: _____ Date: _____

HEALTH SAVINGS ACCOUNT (HSA) CARD

Full Name on Credit Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Account Number: _____ Expiration MM/YY: _____ CSV Code: _____

By signing this Credit Card Authorization Form, I agree to allow my credit card to be charged as stated above and I attest that the information I have provided is accurate and truthful.

Cardholder Signature: _____ Date: _____