Trent C. Holmberg, M.D.

12481 S. Fort Street, Suite 275
Draper, Utah 84020

Authorization to Charge Credit Card

Credit Card Information:

Credit Card Number_________________________________ **Exp:**__________

Name As It Appears On Card: _______________________________________

Zip Code Associated with Card: ___________ **Card Security Code:** ________

I, ______________________ authorize Trent C. Holmberg, MD, PC to charge my credit card for the full amount of my visit or for the each visit of the patient listed below. My relationship to this patient is ______________________.

Payments will generally be processed on the same day of treatment or services, but could be a few days later. I further understand that my card will automatically be charged without prior notice for any missed appointments or late cancellations. I understand that my credit card information will be kept safe and confidential and will only be accessed by authorized office staff when needed. I understand that it is my responsibility to keep my credit card information current and notify Dr. Holmberg's office if my credit card information changes or becomes invalid. I have the right to revoke this information at any time if I no longer wish to keep my credit card information on file. I acknowledge that I have read the above information and understand it completely.

Signature_______________________________________**Date:**____________

Patient Name:__________________________ **Date of Birth:**_______________

Revised 12-13-16