Patient Payment Authorization Form

Patient Information

- **Full Name: _____**
- **Patient ID/Account Number: _____**
- **Contact Information: _____**

Payment Details

- **Payment Method: [ ] Credit Card [ ] Debit Card [ ] ACH Transfer**
- **Payment Amount: $ _____**
- **Frequency: [ ] One-Time [ ] Recurring**

Authorization Statement

[ ] I authorize the clinic to charge my selected payment method for services provided.

Card/Bank Details

- **Card/Account Number: _____**
- **Expiration Date: _____**
- **Bank Name (if applicable): _____**

Acknowledgment and Signature

- **Patient Signature: _____**
- **Date: _____**