CREDIT CARD CONSENT POLICY FORM

I, the undersigned, authorize Dr. Laura Holdcraft to keep my credit/debit card information on file and to charge my credit or debit card ONLY under the following circumstances:

• Missed appointments or appointments cancelled with less than 24 hours notice will be charged $75.00.

• Any service which is being paid on a self-pay basis, either by agreement with Dr. Holdcraft or due to the service not being covered by insurance.

I, the undersigned, understand that this agreement will be valid during my treatment with Dr. Holdcraft unless written cancellation is provided.

Patient's Name _____ Cardholder's Name_____

Credit Card Number On file with Square

Expiration On file with Square

3-digit Security Code On file with Square

Cardholder's Signature _____ Date _____/_____/_____