Lynn E. Lytton MD

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Credit Card Authorization

PLEASE PROVIDE ONLY THE LAST FOUR DIGITS OF THE CREDIT CARD

Please complete all fields. You may cancel this authorization at any time by calling our main number listed above and speaking with Jessica or Tammy Scott

Card Type

_____ Visa ____ Mastercard ____ Discover Other: _____

Card holder's name as shown on card:_____

Credit card number LAST FOUR numbers only: XXXX XXXX XXXX_____FOR YOUR SECURITY **Please provide only the last four credit card numbers.**

This form will be kept with your / patient medical records and our system is set up for HIPPA compliance which differs from financial encryption systems. Our staff will call and get the entire credit card number from you and enter it into our third-party payment system which does have the proper encryption for financial information.

Credit card Expiration date: ____/_____

Billing address including zip code if different from patients address. _____

Phone Number _____ We reserve the right to contact you by phone to verify permissions. For the use of third-party cards used for patient payments we may also ask for a photo ID of the credit card holder to protect against fraudulent use.

I, _____,(PRINT name of credit card holder) authorize Dr. Lynn Lytton, MD / designated staff at MAPS For Recovery to charge my credit card above for services rendered, (doctor visits, bridges, testing). I understand a third party "Clear Gage" will be processing my payments.

Unless otherwise arranged with staff beforehand my credit card will be charged one business day prior to scheduled doctor's visits.

If you do not wish your credit card information to be kept on file for future use, please let us know when we call for the entire card number.

Permission to store any and all credit card information can be revoked at any time by calling our main number and speaking with Jessica.

By signing I am stating that I am legally authorized to use this card.

Authorized Signature: _____ Date: _____

If the cardholder is different than the patient, please include the name of the patient.

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