CREDIT CARD AUTHORIZATION FORM

Business Name: _____
Clinic Name _____
Clinic Address: _____
City, State, ZIP: _____
Phone Number: _____
Email: _____

CREDIT CARD INFORMATION

Cardholder Name: _____
Billing Address: _____
City, State, ZIP: _____
Credit Card Type:
- [ ] Visa
- [ ] MasterCard
- [ ] American Express
- [ ] Discover

Credit Card Number: _____
Expiration Date (MM/YY): _____ / _____
CVV Code: _____

AUTHORIZED CHARGES

I authorize RomoDoc to charge my credit card for the following:

- [ ] Recurring charges for monthly services charged weekly

TERMS AND CONDITIONS

1. I authorize RomoDoc to charge the credit card listed above for services rendered.
2. I understand that this authorization will remain in effect until I cancel it in writing.
3. I agree to notify RomoDoc of any changes to my payment information at least 7 days prior to the next billing date.
4. I acknowledge that any declined payments may result in service suspension until payment is received.
5. I understand that any disputes regarding charges must be addressed within 30 days of the charge date.
6. I certify that I am an authorized user of this credit card and will not dispute the payment with my credit card company, provided the transaction corresponds to the terms indicated in this form.

Cardholder Signature: _____
Date: _____

FOR OFFICE USE ONLY
Authorized By: _____
Date Processed: _____