AUTHORIZATION FORM for CREDIT CARD ON FILE

I, _____, authorize The Kaplan Center for Integrative Medicine to maintain my credit card information on file for future charges against my account. I understand my information will be kept encrypted in the system and all paper copies of the information will be destroyed once entered. I also understand that I will receive a copy of the credit card payment by email. I have the right to cancel this authorization at any time by giving written notice.

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Type: ☐ MasterCard ☐ Visa ☐ Amex ☐ Discover

Credit Card #: _____ Exp Date: _____ CVC: _____

Billing phone #: _____

Email address for CC receipt: _____

Authorized for:

$36.00 Quarterly Administrative Charge: _____ (Initial)

Automatic Charge for office visits (Virtual Checkout): _____(Initial)

Claim filing charge of $10.00 per date of service: _____(Initial)

Fee slips will be sent via the Kaplan Patient Portal for all patients who are registered.
All other Fee Slips will be ☐ mailed or ☐ faxed to fax #: _____

I authorize above card to be used for the following patient account(s) also:

_____

_____

Signature _____ Date _____

Please return this form by your next visit.

IMPORTANT: Do not email this document back to us as it is not a secure method of communication. If you have a patient portal account and a scanner, this form can be scanned and sent to us via the patient portal.

You may fax it back to: 703-237-3105

If you would like to return it by mail, please send it to: Attn: Denita
Kaplan Center for Integrative Medicine
6829 Elm St., Suite 300
McLean, VA 22101