Deborah L. Carle, Ph.D.
11111 Nall Avenue, Suite 224
Leawood, KS 66211
Phone: (913) 549-4390; Fax: (913) 549-4392

CREDIT CARD AUTHORIZATION

Client Name: _____ DOB: _____

Billing Address *(Associated with card)*: _____
Street Address

_____
City State Zip Code

Phone Number: _____

IS THIS AN HSA/FSA CARD? YES ☐ NO ☐ **(IF YES, ANOTHER CARD MUST BE KEPT ON FILE)**

Credit Card Number: _____ Visa ☐ MasterCard ☐

Expiration Date: _____ CVV: _____
(3-digit code on back)

SECONDARY CREDIT CARD *(Only required if primary card is an HSA/FSA)*
Visa ☐ MasterCard ☐ Discover ☐ American Express ☐

Credit Card Number: _____

Expiration Date: _____ CVV: _____
(3-digit code on back)

By signing, I authorize Deborah L. Carle, Ph. D., LLC to charge my credit/debit/HSA/FSA card for services rendered; including but not limited to copays, co-insurance, no-show/late cancellation fees, or balances on the account. I also acknowledge and agree by signing, it is my responsibility to update Dr. Carle with any changes on the card.

_____ _____
Signed Cardholder Name Date

_____
Printed Cardholder Name

****PLEASE DO NOT EMAIL THIS FORM. IF YOU ARE UNABLE TO FAX IT, PLEASE CALL.****