Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential. This form will be kept in your file for billing purposes.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard (NO DISCOVERY/AMEX ACCEPTED)

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge**: $ 30.00 (USD) (THIRTY-FEE US DOLLARS ONLY)**

I authorize ST CLOUD EYE FLORIDA DBA EYE FLORIDA to charge $30.00 USD FOR EVERY N0-SHOW/<24 HOUR CANCELLATION FOR MEDICAL/VISION EYE EXAMINATION APPOINTMENT according to ST CLOUD EYE CENTER DBA EYE FLORIDA OFFICE FEE SCHEDULE, IN WHICH I HAD A CHANCE TO REVIEW AND AGREED TO THE TERMS, as listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date
Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following: EYE FLORIDA, 4589 HENRY C. YATES LANE, ST CLOUD, FL 34769