Name of Patient: _____ Birthdate: _____

This document authorizes the staff of *The Clinic* to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above.

Card Type: ☐Visa ☐Mastercard ☐Amex ☐Debit

Card Number: _____ Exp. Date: _____

Name on Card: _____ Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I understand that billed services will be subject to the parameters agreed upon between myself and my treating clinician and outlined in the "Policies and Procedures Agreement." I have received a copy of this agreement and understand these policies.

Signature of Cardholder: _____

Date:_____

THE CLINIC
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SAN FRANCISCO, CA 94117
PH **415-843-1523** **WWW.THECLINICCA.ORG** FAX **415-484-7083**