I (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize Donnybrook Natural Health Clinic to charge my credit card for, and if need be due to mitigating circumstances which prevented normal payment the day of, a consultation, and/or services rendered, supplements, and/or other items (herbal & nutritional medicines, natural health supplies, tests etc), or any outstanding missed appointment fee as stated in the Welcome/Introductory Information. Below is the appropriate credit card information:

|  |  |
| --- | --- |
| Credit Card Type Only Visa or MasterCard accepted |  |
| Name on Card |  |
| Credit Card Number |  |
| CVV (3 digit security number on back) |  |
| Expiry Date |  |
| Signature of Credit Card Holder  |  |
| Date |  |
| Your Name as a client with Donnybrook Natural Health Clinic  |  |
| By signing above you agree to the above terms above in this form, and that the information you have provided is true and correct |