MIDWEST INTEGRATIVE HEALTH LLC

MIH - CC Consent

AUTHORIZATION FOR CREDIT CARD PAYMENT

Card Number

Name (as it appears on card):

Expiration Date:

Security Code:

Billing Address:

Billing City/State:

Billing Zip Code

Authorization

I/we authorize my provider from Midwest Integrative Health, LLC to bill the above credit / debit card for professional services as outlined in the Policies. I will notify Midwest Integrative Health LLC, in writing if I no longer want my credit / debit card billed. FEES FOR ALL SERVICES ARE DUE AT THE TIME OF SERVICE and this card will be run for fees at time of service.

Date