DONALD K SHIFLET, DC
CHIROPRACTIC PHYSICIAN

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX
Cardholder Name (as shown on card):
Credit Card Number:
Expiration Date (mm/yy):
CCV/CVV Number:
Cardholder ZIP Code (from credit card billing address):

I, _____, authorize **The Back Alley Chiropractic** to charge my credit card above for any agreed upon services rendered. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Card Holder Signature Date

2060 E Tangerine Rd #182, Oro Valley AZ 85755 **PHONE** (520) 877-2666 **FAX** (520) 877-9183