THE BACK ALLEY
CHIROPRACTIC & MASSAGE

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 ☐ Debit
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 **Back Benders Inc d.b.a. The Back Alley Chiropractic & Massage** 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. I understand there is a surcharge of 3% imposed on all brands of credit card transactions that is not greater than our cost of acceptance. I understand I may avoid this extra fee by paying with cash or personal check.

_____ _____

Card Holder Signature Date

---------- *Complete Only If Applicable* ----------

Furthermore, I hereby authorize **Back Benders Inc d.b.a. The Back Alley Chiropractic & Massage** to charge my credit card above for any agreed upon services rendered for the named person listed below. I understand that my information will be saved to file for future transactions on the named person's account. I understand I may cancel this authorization at any time by contacting a member of the staff. This authorization will remain in effect until cancelled.

_____ _____

Authorized Person Full Name Date of Birth

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