I ___________________________ authorize Shelton Chiropractic & Wellness to use card information below to pay any invoices for my account.

I have the right to receive a copy of my statement history upon request. I may also revoke the right to use my card at any time. If need to update my primary payment card, I will advise SCW prior to incurring additional charges. If my card is declined, I understand that I will be subject to a fee.

Account Type: ☐ Visa ☐ American Express ☐ MasterCard ☐ Discover

Last 4 Digits of card number: _____________ Expiration Date: _____________

Signature______________________________________ Today's Date _______________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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