Credit Card Authorization Form

Zen Den/ Zen Den Medical Client Full Name

DOB [MM/DD/YYYY]

Phone Number

Email Address

Card Type [Circle One]: Visa | Mastercard | American Express | Discover

Card Number

Expiration Date

By signing the credit card authorization form, I authorize Zen Den / Zen Den Medical to capture my credit card information and securely store my credit card on file. I authorize Zen Den / Zen Den Medical to charge my credit card on file for any balance owing on the indicated account up to $ 999. I agree Zen Den / Zen Den Medical may charge my credit card on file for the balance due when they receive a copy of the EOB. This authorization relates to all balances not covered by my insurance company for services provided by Zen Den / Zen Den Medical.

This may include amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios only.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Zen Den Medical. Written notice must be submitted to Zen Den/Zen Den Medical, 392 Washington St, Norwell, MA 02061.

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.

Card Holder Name [Print Clearly]:

Card Holder Signature

Date