Credit Card Payment Authorization

Sign and complete this form to authorize the merchant below to make a **one-time charge** to your Credit Card listed below.

By signing this form, you give us permission to debit your account for the **no show fee of $50.00** if you do not contact our office within 48 hours of your scheduled appointment time to cancel or reschedule.

I, _____, authorize **Family Beginnings, PC** to charge my Credit/Debit Card.

Billing Details
Billing Address: _____
City, State, Zip code: _____
Phone Number: _____
Email: _____

Credit Card Information

- ☐ Visa
- ☐ Mastercard
- ☐ American Express (Amex)
- ☐ Discover

Cardholder's Name: _____
Credit Card Number: _____
Expiration Date: ____/____
Security Code: _____

Individual's Signature: _____ **Date:** _____

Please email completed and signed authorization form within 24 hours to kwinn@ivf-indiana.com. Failure to do so will result in an appointment cancellation.

If you have any questions please give our office a call at 317-595-3665.