CREDIT CARD AUTHORIZATION FORM

For treatment deposits, individual services, and prepaid treatment packages

CLIENT AND APPOINTMENT INFORMATION

CLIENT LEGAL NAME

PREFERRED NAME

DATE OF BIRTH

EMAIL ADDRESS

TELEPHONE

CLIENT NUMBER IF KNOWN

CLINIC LOCATION

☐ Calgary ☐ Winnipeg ☐ Regina

APPOINTMENT DATE

PROVIDER

TREATMENT OR PACKAGE SELECTION

☐ Treatment Deposit ☐ Single Treatment ☐ Treatment Package

TREATMENTS OR PACKAGES OF CHOICE	SESSIONS	PRICE CAD

AUTHORIZED PAYMENT AMOUNT CAD

PACKAGE OR TREATMENT TOTAL CAD

BALANCE REMAINING CAD

SECURE HANDLING REQUIRED

Return only through an approved secure method. Do not email or text the completed form unless an approved encrypted process is used.
The CVV is for immediate processing only and must be destroyed or permanently removed after authorization. Never retain it.

PAYMENT DETAILS AND CLIENT AUTHORIZATION

Complete for an authorized treatment deposit, service, or package payment

CARDHOLDER AND BILLING INFORMATION

NAME EXACTLY AS SHOWN ON CARD

CARDHOLDER TELEPHONE

BILLING STREET ADDRESS

UNIT OR SUITE

CITY

PROVINCE OR STATE

POSTAL OR ZIP CODE

COUNTRY

CREDIT CARD INFORMATION

☐ Visa ☐ Mastercard ☐ American Express ☐ Other

CREDIT CARD NUMBER

EXPIRY /

CVV

CARDHOLDER AUTHORIZATION

I authorize EB Medical Centres and its approved payment processor to charge the credit card identified on page 1 for the treatment deposit, service, or package amount stated on this form. I confirm that I am the cardholder or an authorized user and that the billing information is correct. This authorization applies only to the amount shown unless I provide separate written authorization. Treatment, appointment, cancellation, package, and refund terms remain subject to the applicable signed clinic agreement and policies.

CARDHOLDER SIGNATURE

SIGNATURE DATE

CLIENT ACKNOWLEDGEMENT

CLIENT SIGNATURE IF DIFFERENT FROM CARDHOLDER

DATE

Payment authorization only — this form does not replace treatment or medical consent.

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CLINIC AND PAYMENT PROCESSING RECORD

Complete internally and attach to the client authorization pages

CLIENT AND TREATMENT REFERENCE

CLIENT NAME

CLIENT NUMBER IF KNOWN

PRIMARY TREATMENT OR PACKAGE

AUTHORIZED AMOUNT CAD

EB MEDICAL REPRESENTATIVE INFORMATION

REPRESENTATIVE NAME

REPRESENTATIVE EMAIL

REPRESENTATIVE TELEPHONE

CLINIC OR DEPARTMENT

REPRESENTATIVE SIGNATURE

DATE

PAYMENT PROCESSING RECORD

PROCESSING CONTACT

TRANSACTION OR APPROVAL NUMBER

DATE PROCESSED

AMOUNT PROCESSED CAD

BALANCE REMAINING CAD

RECEIPT SENT TO

RECEIPT DATE

INTERNAL COMPLETION CHECKLIST

- [ ] Treatment or package confirmed
- [ ] Clinic payment policy confirmed
- [ ] Payment approved
- [ ] Approval number recorded
- [ ] Receipt sent to client
- [ ] Client and clinic records updated
- [ ] CVV destroyed or permanently removed after processing

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