HORIZON
NURSING SERVICES

AUTHORIZATION TO BILL CREDIT CARD

DATE: _____

CLIENT'S NAME: _____ SS#: _____
(Last 4 digits)

CLIENT ADDRESS: _____

CARDHOLDER'S NAME: _____

CARDHOLDER'S BILLING ADDRESS: _____

_____

PLEASE CIRCLE CARD TYPE BELOW:

TYPE OF CARD: VISA MASTERCARD AMERICAN EXPRESS

CREDIT CARD # _____

EXPIRATION DATE: _____ CVC#: _____
3 or 4 digit security code

BILL CREDIT CARD FOR SERVICES: ☐ YES ☐ NO –Use for Security

I UNDERSTAND THAT BY SIGNING BELOW I AM ACCEPTING FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED AND I AM AUTHORIZING HORIZON NURSING REGISTRY, INC. DBA HORIZON NURSING SERVICES TO BILL THE CREDIT CARD ABOVE. I AM ALSO VERIFYING THAT I AM AN AUTHORIZED USER FOR THE ABOVE LISTED CREDIT CARD.

I UNDERSTAND AND AGREE THAT IF THIS CARD IS BEING USED FOR SECURITY PURPOSES ONLY AND PAYMENT IS NOT RECEIVED FOR SERVICES RENDERED THAT THIS CARD WILL BE AUTOMATICALLY BILLED FOR ANY OUTSTANDING BALANCES.

_____ _____
Cardholder's Signature/Client or Guardian Signature **Date**

_____
(If cardholder different from client, please indicate relationship to client)

ADMINISTRATIVE USE ONLY

To be completed when verbal authorization is received:

Verbal Authorization received from: _____ _____
Print Name Relationship to Cardholder

Completed by: _____ _____ _____
Print Name Signature Date

White Copy: Office Yellow Copy: Client
Revised 12/2014