94-1221 Ka Uka Blvd., Suite B202
Waipahu, HI 96797
Ofc (808) 389-9369
Fax (808) 671-0222

NAME OF PATIENT: _____

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

City:_____ State: _____ Postal Code: _____

Email: _____ Direct Telephone: (_____) _____ - _____

PAYMENT INFORMATION:

☐ I authorize Grace Works, LLC a one-time charge against my credit card ending in _____for the following amount: $_____

☐ I authorize Grace Works, LLC a recurring charge against my credit card ending in _____ for the following amount: $_____ for each visit plus tax. (Please note that this amount will change based on your insurance coverage as well the type of session held at the time of service. Your credit card will be charged accordingly.)

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover Card

Number:_____

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_____ Date:___/___ /____

Security Code: _____ (found on the front of AMEX and on the back of VISA and MC)

I hereby authorize Grace Works, LLC to charge my office visit to the above credit card for the account listed above. I certify that I am the authorized cardholder of record and that I have full authority to make purchases on behalf of the account listed above. I understand that my insurance coverage might change as well as the session held in which that will reflect a different amount on my recurring charge.

SIGNATURE OF CARDHOLDER: _____ **DATE:** _____

PRINTED NAME: _____