



Credit Card Debit Authorisation Form

Declaration

I, _____, (Date of Birth: ____ / ____ / _____), hereby authorise Vitality Healthcare Medical Centre to debit consultation fee (either medicare or private billings), cancellation fee (for any of my consultations which is unattended or cancelled/rescheduled within 5 hours prior to the scheduled appointment time) or any outstanding accounts required from the credit card provided below.

Signature of patient: _____

Date: _____

Personal Details

Cardholder Name:
Credit Card Number:
Type of Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Card Expiry Date (MM/YY):
CVV Validation Code (3 digits on back of credit card):

Signature of credit card holder: _____

Address of credit card holder: _____

Contact Telephone: _____

Practice only

Staff Name: _____ Date: _____