Credit Card Authorization:

I, (Please print name) _____, understand that it is the Regenerative Medicine Center's policy to keep a credit card number on file. I understand that my credit card will not be charged without my prior authorization, unless I fail to cancel my appointment within 48 hours prior to my appointment date.

Signed: _____

Date: _____

C.C: Type: MC VISA Discover

#: _____-_____-_____-_____

Expiration: ____/____ Address:_____ Zip:_____

Preliminary Appointment: _____

Dr. Brock/ Dr. Zuschke Appointment: _____