

Credit Card On File Authorization

I hereby authorize Wicked Skin Med Spa to process my Visa, MasterCard, Discover, or AMEX within 24 to 48 hours after services are rendered. I understand that my information will be **securely** stored for future transactions on my account.

Client Information

First name: _____ Middle initial (if applicable): _____ Last name: _____

Suffix (if applicable): _____ (Jr., Sr., III, etc.)

Billing Address: _____

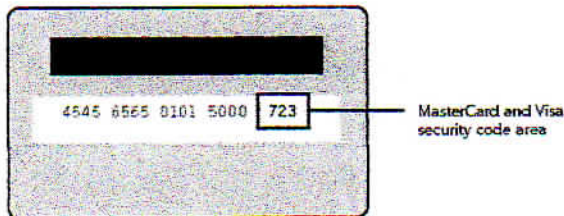
City: _____ State: _____ Zip: _____

Payment: A valid and current card bearing a Visa, MasterCard, American Express, or Discover logo is required for payment. A credit card, debit card, or pre-paid cards are accepted.

Type of Card: Visa MasterCard American Express Discover

Credit Card No.: - - -

Expiration Date: _____ / _____ Security Code: _____
Month Year (Diagram Below)



I, the undersigned, understand that it is my responsibility to review my invoice for accuracy prior to the charge date and that this authority will remain in effect until cancelled by either party with 30 days written notice.

A \$35 return charge fee will be due for non-payment of card.

A \$25 fee will be due for late cancellations and missed appointments.

Print Name _____

Signature _____

Date _____

CHARGEBACKS: Clients agree not to claim any chargebacks or credits from their credit/debit card issuer for any fees charged to their credit/debit card(s), including but not limited to advance payment or deposits, fees for services rendered, late fees, or no-show/cancellation fees.