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Permission to Charge

Please print

Patient's Name _____ Date of Birth _____
has my permission to charge their office visit with the Physician's Weight Control and Wellness Center to my

- Credit Card
- Flex / HSA Card

A copy of your Picture ID must be attached to this completed form.

As the **Credit Card Owner**, I agree to pay for the office visits according to my card issuer agreement.

Name on Credit Card _____
Relationship to Patient _____
Card Holder's day phone _____ Cell phone: _____
Type of card _____ Expiration date _____
CARD NUMBER: _____ Card Security Code _____

As the **Flex / HSA Card Owner**, I agree to pay for the office visits according to my card issuer agreement.

Name on Flex / HSA Card _____
Relationship to Patient _____
Card Holder's day phone _____ Cell phone: _____
Type of card _____ Expiration date _____
CARD NUMBER: _____

Signature of card holder

NAME: _____ **DATE:** _____

Duration of permission: This permission form will be effective for six (6) months. If you would like to give this person permission to use your card for a longer period of time you must fill out another form at the end of the six months.

If for any reason you as the Card Holder should dispute any charges from the Physician's Weight Control and Wellness Center you will need to contact the patient and the patient will contact us personally to dispute any charges to your account.