Otto Puempel, D.O.
Patrick Kirlin, D.O.
Christopher Puempel, M.D.
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Dallas, TX 75214
214-827-1060 Fax 214-827-1266

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.