Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: _____ Mastercard _____Visa _____Discover _____ AMEX _____ Other
Cardholder Name (as shown on card): _____
LAST 4 DIGITS of Card Number: _____
Expiration Date (MM/YY): _____
Cardholder zip code (from credit card billing address): _____
CVV CODE: _____

I, _____, authorize _____ to charge my credit card for agreed upon medical services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature **Date**