Credit Card Authorization

I, _____(name of credit card holder) give _____(name of patient) authorization to utilize my credit card as payment for services. I authorize Penny Chow, M.D., P.A. to keep my signature on file and charge my Master Card, Visa, American Express, or Discover account for that purpose. I understand session time has been reserved for the patient, therefore telephone conferences, missed appointments, or appointments that are cancelled / rescheduled less than 24 hours are promptly charged to my credit card on file. I understand I may cancel this authorization through written notice at any time.

Credit Card #: Visa/MC/Disc./Amex. _____

Expiration Date:_____ CVC:_____

Name on Credit Card: _____

Last 4 digits of Social Security # for credit card holder: _____

Authorized by (printed name):_____

(Signature): _____