CREDIT CARD AUTHORIZATION FORM

PLEASE PRINT CLEARLY

Name on Card _____

LAST FIRST MIDDLE

Address_____

STREET CITY STATE ZIP

I hereby authorize Michael Juboori M.D., to charge my credit card for any outstanding balance not paid within one week after _____ (patient name)'s appointment.

Card Type:

□ MasterCard □ Visa □ Discover □ American Express

Credit Card Number _____ Expiration Date _____

Verification Code _____

(last three digits on signature panel for most cards; four digits on front of AMEX card)

Billing Address

□ Same as above

□ Different from above

Address _____

STREET CITY STATE ZIP

Phone Number Associated with Account _____

Signature _____ Date _____