

## Credit Card Authorization Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I, \_\_\_\_\_, authorize Dr. Ashok Jain to automatically deduct \$ \_\_\_\_\_ from my credit card on the \_\_\_\_\_ of every month until my account balance is paid in full.

Guarantor: \_\_\_\_\_

Witness: \_\_\_\_\_

Name as it appears on the Credit Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Type of Credit Card:    Master Card        Visa        Discover        American Express