CREDIT CARD AUTHORIZATION FORM

PLEASE PRINT CLEARLY

Name on card _____

Address _____

City, State, Zip _____

I hereby authorize

_____Lauren Prasek, PMHNP-BC _____Deomel Soriano, PMHNP-BC _____ Dr. Esther Samadi, MD

to charge my credit card for any outstanding balance not paid within one week after _____ (patient name) appointment.

Card type: □ MasterCard □Visa □Discover □American Express

Credit card number_____ Exp _____

Verification code _____ (last 3 digits on signature panel; 4 digits on front of AMEX card)

Billing address

□same as above

□different from above

Address _____

City, State, Zip _____

Phone number associated with account _____

Signature _____ Date _____