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CREDIT CARD AUTHORIZATION FORM

PATIENT NAME:

_____
Print Last Name First Name Middle Initial

NAME ON CARD (IF DIFFERENT):

_____
Last Name First Name Middle Initial

BILLING ADDRESS:

_____

CITY: _____ STATE: _____ ZIP CODE: _____

BILLING PHONE NUMBER: _____

E-MAIL: _____

TYPE OF CARD (Check One): ☐ Visa ☐ Mastercard ☐ Other: _____

CARD HOLDER SIGNATURE: _____

DATE SIGNED: _____

I authorize Dr. Sherbak to charge my card for professional services as follows:

_____ Co-Pay defined by your insurance payer, each visit automatically
(initial)

_____ Account Balances not paid by my insurance company within 90 days
(initial)

OFFICE NOTES:

_____

_____

_____