Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX
☐ Other _____

Cardholder Name [as shown on card]: _____

Card Number: _____ CVV Code: _____

Expiration Date [mm/yy]: _____

Cardholder ZIP Code [from credit card billing address]: _____

I, _____, authorize Curtis Haskins, MD to charge
Print Name on Above Line
my credit card above for agreed upon medical services. I understand that my information will be saved to file for future services/office visits.

_____ _____
Patient or Representative Signature Date