Credit Card Authorization Form

I, _____, hereby authorize Saad A. Shakir M.D. and Associates Inc, to charge my credit card for the amounts invoiced.

Patient's Name: _____

Name on card: _____
(If different from patient's Name)

Type of Card: AMERICAN EXPRESS / DISCOVER / VISA / MasterCard / OTHER
If other, please specify:

Credit Card Number: _____
Expiration Date: _____
CVC Code: _____

Credit Card Billing Address
Street: _____
City: _____
State: _____
Zip Code: _____
Telephone: _____
Email (optional): _____

As the credit card holder, I also authorize Saad A. Shakir M.D. and Associates Inc. to charge my credit card for future services and also for late cancellations or failed appointments.

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Saad A. Shakir M.D. and Associates Inc. will keep all information entered on this form strictly confidential.

Cardholder's Signature: _____
Cardholder's Name: _____
Date: _____