Credit Card Authorization Form

Patient Information

Name: _____ Date of Birth: _____

Phone Number: _____

Email: _____

Cardholder Information

Name on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Credit Card Information

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number: _____

Expiration Date: _____ CVV: _____

Authorization

I, the undersigned, authorize Intentional Dermatology and Health to charge the credit card listed above for the following (check all that apply) on the next business day of my services:

☐ Office Visits

☐ Cosmetic Procedures

☐ Surgery or Biopsies

☐ Skincare Products

☐ Other: _____

I understand that this authorization will remain in effect until I provide written notice to revoke it. I agree to notify Intentional Dermatology and Health of any changes to my account information in a timely manner. I certify that I am an authorized user of this credit card and will not dispute the payments with my credit card company, so long as the transactions correspond to the terms indicated in this form.

Cardholder Signature: _____ Date: _____