IRREVOCABLE CREDIT CARD AUTHORIZATION

Name of Patient:____

Chart # (if applicable): ______________________________________

Date of Service: ____

Type of Service: ________________________ Deposit ☐ Yes ☐ No

Amount of Charge: $ ____

Credit Card Number: ____

Credit Card Type: Check One ☐ VISA ☐ M/C ☐ AMEX ☐ DISCOVER

Expiration: ________________

Security Code: VISA/MC (3 digits) ________ AMEX (4 digits) ________

Name of Credit Card Holder: __________________________________

Billing Address of Credit Card:_______________________________

City: ________________ State: ______________ Zip Code: __________

Phone Number: __________________________

Signature of Credit Card Holder:______________________________

Employee: ____

- A legible & valid copy of a state issued drivers license or government photo ID with credit card holder's signature must be attached.

My signature above indicates that I am approving the above related charges and that I may not cancel the authorization after my approval.

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Vivian Chin, MD, MPH
Medical Director
341 East 78th Street, New York, NY 10075
917-773-8878