**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.

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| **Credit Card Information** |
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX  □ Other |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (mm/yy): |
| Security Code: |
| Cardholder Billing Address: |

I, , authorize Dr. Parisa Shoja to charge my credit card above for fees for services or for late cancellations and/or no show fees. I understand that my information will be saved on file for future transactions on my account and will remain in effect until revoked in writing. If a charge on my card is denied I agree to make payment once I become aware of the denial in cash or check.

Signature Date