

Credit Card Authorization

Dr. Michael J. Thomas

Credit Card Information (*note: credit cards only. No debit cards.*)

Card Number: _____ Exp. Date _____ V Code _____

Card Holder Name _____ Phone Number _____

Billing Address _____
Street City State Zip

Our Commitment to You

- We keep your credit card information **locked** safely away.
- Your information is always kept **confidential** and **private**.
- We **do not share** your credit card information with anyone.
- We only charge your credit card for services provided to you or to those you designate below.
- You will **always** receive a **receipt** when we charge your credit card.

Authorization

I authorize Dr. Thomas to charge my credit card for services provided to me and the following patients:

Patient 1 _____

Patient 2 _____

Patient 3 _____

Name- printed

Signature

Date

