Credit Card Authorization Form

I, _____, hereby authorize the office of David Brian Wexler, MD, to charge my credit card for regularly scheduled visits, missed or phone appointments, or as otherwise indicated.

( ) Visa ( ) MasterCard ( ) Discover ( ) American Express

Credit Card Number: _____

CVV: _____ Expiration: _____

Credit Card Billing Address:

Name (exactly as indicated on card) _____

Street: _____

City: _____ State: _____ Zip:_____

Telephone: (_____)_____ Cell: (_____)_____

I understand that the doctor requires payment at time of visit by cash, check, or credit card. A valid credit card number will be required for our files. In the event of a late cancellation, missed or phone appointment, your card will be charged accordingly.

_____ _____

Cardholder's Signature Date

Your completion of this authorization form helps us to protect you from credit card fraud. We will keep all information entered on this form strictly confidential.

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