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Credit Card Payment Authorization Form

Sign and complete this form to authorize Priti M. Kothari, M.D. P.A. to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction or recurring transaction, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Priti M. Kothari, M.D. P.A. to charge my credit card
(full name)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

For your convenience, we offer the option of adding a credit card to your account for future payments. Would you like us to keep your card on file? [ ] Yes [ ] No

SIGNATURE _____ DATE _____