CREDIT CARD AUTHORIZATION FORM

Alan R. Jacobs, MD. PC.
120 EAST 56TH STREET, SUITE 1040
NEW YORK, NEW YORK 110022
212-888-0002
Please email the completed form to:nurse@alanjacobsmd.com

I authorize Alan R. Jacobs, MD. PC. to charge following credit or debit card:

☐Amex ☐Visa ☐MasterCard ☐Discover

Credit Card Number _____

Expiration Date ____ / ____ / ____

(Security code to be provided at time of visit to protect your privacy)

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request **Alan R. Jacobs, MD. PC**. to charge my credit card, indicated above, for services rendered for medical services provided and acknowledge this to be as my financial responsibility. The fees are listed below.

☐Initial Consultation ($725.)
☐Follow-up Visit ($525.)
☐20 min phone follow-up ($195.)

This authorization relates to all payments for services provided to me by Alan R. Jacobs, MD. PC. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Alan R. Jacobs, MD. PC. in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____ / ____ / ____