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CREDIT CARD AUTHORIZATION FORM

Alan R. Jacobs, MD. PC.
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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 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: ____ / ____ / ____