



Alan R. Jacobs, MD.

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### CREDIT CARD AUTHORIZATION FORM

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

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 (\$550.)     Follow-up Visit (\$250.)

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_