Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other_____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____ , authorize Don Mehrabi MD APMC dba BHSkin Dermatology, Inc. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I authorize all pending balances and statement balances to automatically be charged when due.

_____

Customer Signature Date