# CREDIT CARD AUTHORIZATION FORM

**Cardholder Information:**

Cardholder's Name: ___________________________________

(as it appears on credit card)

Credit Card Billing Address: __________________________

City, State Zip: _________________________

Phone Number: _________________________

Texas DL #: _________________________

Email address to send receipt: _____________________________

(If you do not have an email address, receipt will be mailed)

**Card Information:**

Amex____Visa____MasterCard____Discover____

Card # __________________________________

Expiration Date: ___/___

**PLEASE SIGN AND FAX/EMAIL BACK TO**

**FAX # 281.586.3808**

**khigginbotham@ikpfamilymedicine.com**

I, ___________________ (cardholder) hereby authorize IKP Family Medicine to bill my credit card for services provided to _______________________(patient name)

_______ One time use for date of service___/___/____

(Card Information will not be kept on file)

________ Please keep my information on file for future use.

Signature of Cardholder: ___________________________ Date: ____________

** It is the responsibility of the cardholder to update information as necessary. **