

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 / Contact Information	
Card Type: <input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
<input type="checkbox"/> Discover	<input type="checkbox"/> AMEX
<input type="checkbox"/> Other _____	
Cardholder Name (as shown on card): _____	Birth Date: _____
Card Number: _____	CVV (3 numbers on back of card): _____
Expiration Date (mm/yy): _____	Cardholder Address: _____
Cardholder ZIP Code (from credit card billing address): _____	Phone # _____

I, (PRINT NAME: _____), authorize DR. DAN SNEIDER-COTTER 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.

Customer Signature: _____

Date: _____