CREDIT CARD AUTHORIZATION

CREDIT CARDHOLDER INFORMATION		
NAME ON CREDIT CARD:		
TYPE OF CREDIT CARD: VISA	Mastercard	Discover
ACCOUNT NUMBER: _	_	_
EXPIRATION DATE:	**Security Code:**	
BILLING ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

AUTHORIZATION OF CARD USE FOR THE OFFICE *OF DR. KUNIYOSHI*:

I certify that I am the authorized holder and signer of the credit card referenced above.

I certify that all information above is complete and accurate.

I hereby authorize collection of payment for all charges as indicated below.

SIGNATURE: **DATE:**

This card is authorized for the following patient(s):

Name:_______________________________________ DOB:_______________________________

Name:_______________________________________ DOB:_______________________________

Name:_______________________________________ DOB:_______________________________

AMOUNT OF PAYMENT:

☐ Auto Pay After Appointments

☐ One-time payment of $_______________________