Jonathan Tobkes, M.D.

115 East 61st Street, Suite 7F
New York, NY 10065
Phone: (212) 861-0763

Credit Card Authorization

Name of Patient: _____

The office requires a credit card to be kept on file as a back-up payment method in the event of bill nonpayment. If, on the prior page, you indicated that you would like to use a credit card to pay for sessions, the card will be charged automatically at time of the session or at the end of the month, depending on your billing plan. Otherwise, cards will only be charged if payments have not been received by their due date.

I am granting permission for Jonathan L. Tobkes, M.D. to bill my credit card as per the above parameters.

Name on Credit Card: _____

American Express Discover Mastercard Visa

Card Number: _____
Expiration Date: _____
CVV Number (3 or 4 digits): _____
Billing Address: _____
City: _____ State: _____ Zip: _____

Signature: _____