Gottesman Medical PC
555 Lefferts Avenue Ste B
Brooklyn, NY 11225
Tel- (646)757-8751

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): ________________________________ Patients Name and DOB:
Card Number: ________________________________ Security Code: ________________
Expiration Date (mm/yy): ________________________________
Billing Address: ____

I,______________________, authorize_________________________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.

Please check one of the one of the options below:

___ Charge my credit card when amount is due.

___ Notify me a day prior to charging my credit card (if I am unable to be reached leave a voicemail notifying me that my credit card will be charged and the amount to be charged).

___ Do not charge my credit until I verbally approve the charge. *

_________________________________ _________________________________
Customer Signature Date

*If there is no response from the responsible party with in 48 hours, I am fully aware that the office has a right to charge my credit card for any and all past or current amount due on my account.