HARSHAD PATEL, MD, PC

4994 LOWER ROSWELL RD, SUITE 29, MARIETTA GA 30068

PHONE: 770-977-2987, FAX: 678-236-6041

Credit Card Authorization Form

Fax completed form to (678) 236-6041

Please complete this form in order to keep your credit card on file only as a guarantee you will be present for all appointments scheduled or courteous if a cancellation is needed. Your card will **NOT** be charged unless you fail to cancel an appointment within **48 hours** of notice or simply do not show up for your appointment. In that case, your card **WILL** be charged **$350** if it is a new patient appointment or **$110** if you are an established patient. *Note: Flexible Spending Account Cards or Benny Cards **can not** be used due to the fact insurance companies will not pay for missed appointments.*

The undersigned agrees and authorizes HARSHAD PATEL, MD, PC to charge the credit card below:

Cardholder Name: ____

Cards Accepted – Visa/ Master Card/Discover/ American Express (Please Circle One)

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date __ __ / __ __ Security Code * __ __ __ __

(Security Code - 3 digit on the back of your card, except AMX – 4 digits on the front of card)

Credit Card Billing Address: ____

City: _________________________ State: _______________________ Zip: _______________________

Authorized Signature: ____