

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 &/or at your termination of treatment with Dr. Melissa Gressner.

Credit Card Information

Card Type: MasterCard VISA Discover AMEX

Other

Cardholder Name (as shown on card):

Card Number:

Expiration Date (mm/yy):

CVV/Secy 3 digit code on back of card:

Cardholder ZIP Code (from credit card billing address):

I, _____ (*CLIENT NAME*), authorize Dr. Melissa Gressner 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

