

CREDIT CARD AUTHORIZATION FORM

Rose Clinic, A Professional Medical Corp.

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American Board of Radiology

Specializes in Anti-Aging, Hormone, Breast and Reproduction

AUTHORIZATION TO CHARGE CREDIT CARD

Note: This signed and dated authorization form must be on file prior to any telephone or initial consults. You may also authorize us to use this card as payment method for called-in orders and / or in person office visits.

I, (print name) _____

Authorize Rose Clinic to bill my credit card.

Name on Credit Card: _____

Address _____

City, State, Zip _____

Credit Card Holder's Billing Address (where your statement is mailed)

Credit Card Information

VISA Card # _____ exp date _____ CVE # _____

MC Card # _____ exp date _____ CVE # _____

(CVE # is the last 3 digests; found on the signature line on the back of your credit card)

Authorization

Card Holders Signature

Date