



## Credit Card Authorization Form

Patient's Name *(printed)*: \_\_\_\_\_

Credit Card Type: \_\_\_\_\_ Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_  
*(This is a 3 digit code found on the back of Mastercard/Visa and 4 digit on front of American Express Cards)*

Relationship to Patient: \_\_\_\_\_

### COMPLETE BILLING ADDRESS

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZipCode: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

*I authorize Nalini Chilkov, OMD to charge the above listed credit card for professional services which includes face to face, telephone and email consultation fees, as well as charges for review of records, re-evaluation or revision of treatment plans, evaluation of diagnostic studies, report writing and herbal and nutraceutical supplements and supplies as well as missed appointment and late payment and back fees as indicated by my signature below:*

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_\_  
Date

Authorized by Telephone

Authorized by Email

Received via FAX      DATE: \_\_\_\_\_