nalini chilkov L.Ac., O.M.D.
DOCTOR OF ORIENTAL MEDICINE

CONFIDENTIAL

Credit Card Authorization Form

Patient's Name *(printed)*:_____

Credit Card Type: Select... 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:

☐ ***By typing in your name, you agree that all the information provided is truthful and accurate and legally binding.***

_____ _____
Cardholder's Signature Date

☐ Authorized by Telephone
☐ Authorized by Email
☐ Received via FAX DATE:_____

PRINT SAVE RESET EMAIL

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