

Monisha Vasa, MD

PAYMENT AUTHORIZATION

I, _____
Cardholder's Name

at _____

Cardholder's Street Address, City, State, Zip, & Phone Number

authorize Monisha Vasa MD for charge(s) to the credit card below for medical services rendered and will not dispute the charge(s) with my credit card company.

Patient name (if not cardholder) _____

Credit Card Number _____

Credit Card Type (Please circle one) Visa / Master Card

Security code (3 digits) _____

Expiration Month/Year _____

X _____
Cardholder's Signature

Date