Jana Colton
(646) 783-0800

Credit Card Authorization

Name of Patient: ____

The office requires a credit card to be kept on file as a back-up payment method in the event of bill nonpayment. If, on the prior page, you indicated that you would like to pay with credit card, the card will be charged at the time of the session or at the end of the month, depending on your billing plan. Otherwise, cards will only be charged if payments have not been made by their due date.

I am granting permission for Jana Colton, MD to bill my credit card as per the above parameters.

Name on Credit Card: ____

American Express Mastercard Visa Discover

Card Number: ____

Expiration Date:____

CVV Number (3 or 4 digits): ____

Billing Address:____

City: _____________________________ State: _____________________ Zip:_______________

Signature:____

Printed Name:____

Date:____