Credit Card Authorization

If you wish to pay by credit card without coming to the office, please fax or email this completed form to 281-540-1164 or drstraka@hotmail.com. **Please include a copy of the credit card (front and back) and a copy of the card holder's driver's license if we do not already have a copy in your file. Payment will not be processed without these items.**

Patient name:_____

I, _____, (please print name as it appears on the credit card) hereby authorize the office of Philip J. Straka, M.D. to charge my credit card in the amount listed below.

Credit Card type: ☐Visa ☐Master Card ☐Discover ☐American Express ☐Care Credit

Credit Card number: _____

Expiration date: _____/_____

Card ID #: _____ (last 3 digits on the back of VISA, MC or Discover OR 4 digits on front of American Express)

Charge amount: _____

Billing address including zip code:_____

_____

I hereby certify that I am the card holder and authorize the office of Dr. Philip Straka to charge the above listed amount to my credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank card holder agreement.

_____ _____

Signature Date