

MY CONCIERGE MD

Executive Health

Credit Card Authorization Form

Name (as it appears on card): _____

Patient's Name: _____

Phone Number: _____

Email: _____

Visa MasterCard Discover Amex

Credit Card Number: _____

Exp: _____ Sec Code: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Authorization Statement:

I authorize **My Concierge MD** and its affiliates to charge my credit card \$_____ for all services rendered. I acknowledge that there are no refunds or returns for any services rendered by **My Concierge MD** and its affiliates.

Print Name: _____

Signature: _____ Date: _____