Optimal Health Physicians
15235 Shady Grove Road, Suite 102, Rockville, MD 20850
Phone: (301) 330-9430 Fax: (301)330-6515 www.ohpmd.com

Credit Card Authorization Form

Patient Name _____ Date of Birth _____

Please complete this Authorization and return to us at:

15235 Shady Grove Road

Suite 102

Rockville, MD 20850

All information will remain confidential.

I authorize _____ to charge the agreed amount listed below to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. Please note below whether the credit card provided will be used for payments indefinitely.

- □ Yes, I want the credit card listed below saved for all future payments.
- □ No, I only authorize use of the credit card listed below for the charge of $_____ on _____ (date).

Cardholder Name: _____

Billing Address: _____

_____

Amount to Charge: $ _____

Credit Card Type: ___ Visa ___ Mastercard ___ Discover ___ AmEx

Credit Card Number: _____

Expiration Date: _____

CCV: _____

Signed: _____

Date: _____

Name (please print): _____