

Authorization for Credit Card Use

All information will remain confidential

Name on Card _____

Billing Address _____

Email Address for Receipt _____

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

Credit Card Number _____

Expiration Date _____

Card Identification Number _____

Amount to Charge \$ _____ Date _____

Amount to Charge \$ _____ Date _____

Amount to Charge \$ _____ Date _____

I authorize Dr. Deidra Bird Kokel, D.D.D., P.C. to charge the amount listed above to the credit card provided herein. I agree to pay this in accordance with the issuing bank cardholder agreement.

Cardholder – Please sign and date

Signature: _____

Date: _____

Print Name: _____