Bernhoft Center For Advanced Medicine

Robin A. Bernhoft, MD, FACS
MEDICAL DIRECTOR

Credit Card Payment Authorization Form

Patient Name _____

To be kept on file for future purchases/service charges:

I, the undersigned being an authorized signor of the following account, hereby authorize the Environmental Health Center and/or Bernhoft Nutritionals to charge to the credit card below for all future purchases or services as may be invoiced from time to time. I understand that I can always request to cancel this authorization on file by providing a request by calling the office and a patient relations coordinator will update your information.

For recurring payment:

I, the undersigned being an authorized signor of the following account, hereby authorize Environmental Health Center and/or Bernhoft Nutritionals to automatically charge to the credit card below for recurring charges on my account.

Credit Card: ___Visa ___MasterCard ___AMEX ___Discover ___CareCredit

Credit Card Number: _____ Expiration (mm/yy): _____

Name on the credit card: _____

Billing address of the card:

_____

CCV number: _____ (Visa/MasterCard: found on the back of the card on signature area, last 3 digits. AMEX: above last card numbers, 4 digits)

_____ _____

Authorized Signature Date

_____ _____

Print Name Date

Contact Person/Telephone/Email in case of any questions on this authorization:

_____(Relation)_____ _____

1200 Maricopa Highway • Suite A • Ojai, California 93023 • phone: 805.640.0180 • fax: 805.640.0181
www.DrBernhoft.com

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