Shawn A. Khavari, MD PLLC

3917 E. Covell Rd
Edmond, OK 73034

Telephone: 405-471-5557
Fax: 405-471-5571

CREDIT CARD AUTHORIZATION FORM

THIS FORM MUST BE COMPLETED ENTIRELY, DO NOT LEAVE BLANKS

Patient Name: ____

Your Name: ____

Relationship to Patient: _______________________________________

Credit Card Number: ____

(WE ONLY ACCEPT VISA OR MASTERCARD)

Expiration Date: ___/____ CV Number: ____________

Billing Address: ____

I understand that the credit card mentioned above will be used to pay the balance in full on this account.

__I would like to be notified when you charge my card.

__By Phone Phone Number ______________________________

__I do not want to be notified when you charge my card.

Signature: _______________________ Date: ___/____/____

Please include a legible copy of the front and back of your credit card and the front of your driver's license.

****If you have questions please call our office****