



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____ CVV: _____
Cardholder ZIP Code (from credit card billing address):	_____

I, _____, authorize Krauss Dermatology to charge my credit card above for agreed upon services, procedures and purchases. I understand that my information will be saved to file for future transactions on my account.

I understand I will be charged a \$75 no show fee if I fail to cancel my appointment less than 48 hours in advance.

This completed form must be emailed to kd@kraussderm.com prior to your scheduled appointment.

Patient Signature & Date