David Stoker, M.D.
Marina View Surgery Center

Credit Card Authorization Form

Credit Card Holder Name: _____

Type of Card: Mastercard Visa American Express

Credit Card Number: _____

Expiration Date: _____

3 Digit Security Code: _____

Billing Address (Including Zip) For Card:

_____

_____

Amount Authorized: _____

Card Holder Signature: _____

Date Authorized: _____

I am the patient and I authorize Dr. Stoker and Marina View Surgery Center to charge my credit card for the amount listed above.

**If you are not the patient and are authorizing payment for someone else, please print the name of the patient below:*

I authorize payment for patient , _____,
(Print Patient Name)
in the amount listed above for services/treatments by Dr. Stoker and Marina View Surgery Center.

*Please include a copy of the front and back of your Credit Card and copy of your driver's license or photo ID.