

CHHOKAR CLINIC
1906 WARM SPRINGS RD
COLUMBUS, GA 31904
(706) 322-0528

Credit Card Pre-Authorization Form

I authorize _____ to keep my
signature on file and to charge the credit card selected below:

☐ **Recurring charges of \$** _____ **to be charged every**
_____ (frequency) **From** _____ **to**

CREDIT CARD PAYMENT FORM

CREDIT CARD INFORMATION	
Patient Name:	
Credit Card Type: Visa Master Card Discover Debit	
Credit Card Number:	Expiration Date:
Name as it appears on Credit Card:	Account#
Payment Amount (US Dollars):	REQUIRED: CVC2 Code:
Signature:	Date:

Please note: We CANNOT process your credit card payment without the required CVC Code. This is normally the 3 digit code listed on the back of your credit card.