Jennifer R. Cooper, MD
177 Prince Street, Suite 402, New York, NY 10012
Tel: 212-879-1970

Credit Card Authorization Form

Card Holder's Name: _____
(exactly as it appears on the card)

Card Holder's Cell Phone Number:_____

Patient's Name:_____

Card type (circle one): MC Visa AmEx Discover

Card Number: _____

Expiration Date (MM-YY) _____

3 or 4 digit Security Code: _____

Zip code of the Billing Address: _____

Phone Number for Text Receipt: _____

I hereby authorize Jennifer R. Cooper, MD to charge the credit card listed above for payment of charges to my account.

This form will remain on file and will remain in effect until the expiration of the credit card. Patients may also revoke this form by submitting a written request to the address listed above.

Card Holder's Signature: _____

Date: _____