# Credit Card Authorization

***Card Holder Information:***

Name (as it appears on card) _____

Cardholder's Address _____

_____

Phone Number _____

Texas Drivers License _____

Email _____

Patient Name (if other than the cardholder) _____

____ I authorize IKP to keep my information on file for future use

____ One time use for date of service ___/___/____

***Credit Card Information:***

____ Amex _____ Visa _____ Mastercard _____ Discover

Card Number _____

Expiration Date ___/___

Zip Code _____

****By signing this, I understand I am allowing IKP to keep my credit/debit card information on file. I am aware my account will NOT be charged without my consent****

_____ ____/____/_____

Cardholder's Signature Date

_____ ____/____/_____

IKP Representative Signature Date