Sahara Medical Institute- 5781 W. Sahara Avenue. Suite 500. Las Vegas, NV 89146

CREDIT CARD AUTHORIZATION FORM

Date: _____

I Authorize Sahara Medical Institute to keep my signature on file and charge my credit card.

Name of Patient: _____

Chart Number: _____

Date of Service: _____

• This Visit Only (_) • All Visits This Year (_)

Cardholder : _____

Cardholder Signature:

_____

Credit Card #

MC: _____ EXP: _____

CV# ____

VISA: _____ EXP: _____

CV# _____

AMEX: _____ EXP: _____

CV# _____ TAKEN BY: _____