

## Recurring Payment Credit Card Payment Authorization Form

Please complete all fields. You may cancel this authorization anytime by contacting  
**Nina Anderson, MD, Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD.**  
**43157 Schoenherr Sterling Heights, MI 48313**  
**PH: (586) 997-9619 or FAX: (586) 997-9635**

Billing Information	
Name, Company, Group, or Organization:	
Address:	
City, State, ZIP Code:	
Phone Number:	Email Address:

Credit Card Information	
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex <input type="checkbox"/> Discover	
<input type="checkbox"/> Other (please specify): _____	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	Security Code (CVV):
Cardholder ZIP Code:	

By signing this form, I authorize **Nina Anderson, MD, Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD**, to charge my account for recurring payments starting on or after \_\_\_\_\_. This authorization will remain in effect until I notify **Nina Anderson, MD, Robert S. Burnstein, MD, Robert Piccinini, DO, or Eleanor Kulis, MD**, before the next billing date.

I confirm that I am an authorized user of this credit card. I understand that my information will be securely stored for future transactions on my account.

CUSTOMER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_