Michael Domash, MD

2215 Broadway Vancouver, WA 98663
Phone: 360-906-7156, Fax: 360-696-3658

Date: ________________________

Patient: ____

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW

CARDHOLDER'S NAME:____

CREDIT CARD BILLING ADDRESS:____

PHONE NUMBER ____

CREDIT CARD: MASTERCARD___ VISA ___ AMERICAN EXPRESS ___DISCOVER___

CREDIT CARD
NUMBER:____

EXP.DATE:_____________ CVV#: _______

I HEREBY AUTHORIZE MICHAEL DOMASH TO CHARGE MY CREDIT CARD ACCOUNT FOR DEDUCTIBLES, CO-PAYS, CO-INSURANCE, LATE CANCELS AND NO SHOW FEES.

CARD HOLDER'S
SIGNATURE:____

DATE: ___/___/________

**Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.**