1049 Fifth Avenue, Suite 2B
New York, NY 10028
(212) 327-2919
www.pfrankmd.com

Credit Card Authorization

Name:________________________________

Address:_______________________________
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Phone:_________________________________
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Credit Card #:____________________________
Expiration Date:__________
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Billing Zip Code:__________

Card type: American Express MasterCard Visa Discover Care Credit

PFRANKMD™ has a 24 hour cancellation policy. 24 hours is required to cancel or reschedule an appointment. If the appointment is not canceled or rescheduled within 24 hours you will be charged $75.00

I authorize PFRANKMD™ to charge my credit card for services rendered and/or cancellation policy.

Please check below:
____ Please keep this credit card on file for future payments.

Signature:________________________________

Print Name:_______________________________

Date:____________________________________