ALISA J. LAND, M.D.
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Los Angeles, CA 90025
TEL: (310) 428-2833
FAX: (888) 558-6693

CREDIT CARD AUTHORIZATION

Provider Name: Alisa J. Land, M.D.

Today's Date: _____

Patient's Name: _____

Patient's Phone Number: _____

( ) Visa ( ) Mastercard

Credit Card Number: _____

Security Code: _____

Expiration Date: _____

Cardholder's Address: _____

City: _____

State: _____

Zip Code: _____

I understand that it is preferred that visits are paid via check or cash. If payment is not made through these preferred means at the time services are rendered, my credit card will be billed for office visits (including missed visits or visits cancelled less than 48 hours prior per office policy).

Cardholder's signature: _____

Cardholder's name (please print): _____