Credit Card Authorization Form
Clear Dermatology

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

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (as shown on card): ________________________________
Card Number: ________________________________
Expiration Date (mm/yy): ________________________________
Cardholder ZIP Code (from credit card billing address): ________________________________

I,___________________________, authorize Clear Dermatology to charge my credit card above for agreed upon purchases, copays and deposits. I understand that my information will be NOT saved to file for future transactions on my account.

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Customer Signature Date