Michael K. Kwok, M.D.

KWOK INTERNAL MEDICINE, A Medical Corporation

CREDIT CARD AUTHORIZATION

Name of patient in Retainer Program:

First Name: _____ Last Name: _____

Address: _____

_____

Telephone: _____

Email: _____

Payer's Billing Information (if different from above):

First Name: _____ Last Name: _____

Billing Address (must match name and billing address of credit card):

_____

_____

Card type (circle one): MasterCard / VISA / American Express

Card Number: _____

Security Code: _____ Expiration Date: _____

I hereby authorize the office of Michael K. Kwok, M.D. to charge this credit card for the annual retainer practice membership fee.

_____ _____

Signature Date

Please return this authorization to our office:

Michael K. Kwok, M.D.

1300 South Eliseo Drive, Suite 203

Greenbrae, CA 94904