N.Y. HOTEL URGENT MEDICAL SERVICES

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One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize NY Hotel Urgent Medical Services to make a one-time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account. **Cancellation less than 48 hours will be charged a 50% cancellation fee and less than 6 hours, a full non-refundable credit card charge will apply.**

Please complete the information below:

I _____ authorize N.Y. Hotel Urgent Medical Services, PC/Ronald A. Primas, MD, to charge my credit card.
(full name)

account indicated below up to the amount of _____on or after _____. This payment is for
(date)

_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ CV _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.