CREDIT CARD AUTHORIZATION FORM
FOCUSED CONCENTRATION LLC

Name as written on the card:____

Type of card (circle):

- **Visa**
- **MasterCard**
- **Debit**
- **Discover**
- **HSA Card**

Account Number: ____

Expiration Date: _____________________________**Security Code:** ______________________________

Billing Address: ____

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Phone Number: ______________________________ **Email Address:** ____________________________

By signing below you authorize FOCUSED CONCENTRATION/Dr. Stella Fernandez to charge the above card on any outstanding balance(s) that are over 60 days old and/or any balance(s) that have not been paid by your insurance.

Signature: ____________________________________ **Date:** __________________________________