

Credit Card Authorization

If you prefer to use your credit card to cover expenses incurred in this office, please supply the following information to expedite this process. Your signature below signifies that this information is true and your agreement and authorization to utilize this signature with future payments.

Name as on front of card: _____

Credit Card Type: _____ Mastercard _____ Visa

Credit Card Number: _____

Expiration Date: _____ Last 3 digits on back: _____

Address where card statement is sent:

Street Address

Zip Code

Patient's Signature

Date