CREDIT CARD AUTHORIZATION

Date _____ Clinician(s) _____

Patient Name _____

Cardholder Name _____

Billing Address (of credit card) _____

Credit Card ( ) Visa ( ) MasterCard ( ) AMEX ( ) Discover

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CCV Code _____ Zip Code _____

Authorizied signature to use credit card(s) _____

Please notify us as soon as possible if credit card information changes.

F3023