Credit Card Payment Authorization Form

Provider's Name:

____

I, ____________________ (card holder's name), agree to process payment to provider

______________________ for a single payment only in the amount of ______________.

Patient Name: ____________________________ Patient Account #: ________________

Credit Card #: _________________________________

Expiration Date: ______________

Three digits on back of card: _______

Four digits on front for American Express: ___________

Card Holder Name: ____________________ Card Holder Phone:__________________

Billing Address: _________________________________

City: _________________________ State: _______ Zip: _______________________

I, ____________________________ hereby authorize __________________________
or designated staff to bill my credit card for services rendered

__________________________________ __________________________

Cardholder Signature Date