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ELECTRONIC PAYMENT AUTHORIZATION

Contact Information:

Patient Name: _____ Date of Birth:_____

Credit/Debit Card Information:

Card Type (check one): ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date: _____

CVV2/CVC2/CID (security code) _____

Account Holder Billing Information:

Name on card: _____

Billing Address: _____

City_____ State: _____ Zip: _____

Phone # _____ _____

Signature of Cardholder

_____