

Practice Name
Address
City State Zip Code
Phone Number
Fax Number

IRREVOCABLE CREDIT CARD AUTHORIZATION

Name of Patient: _____

Chart # (if applicable): _____

Date of Service: _____

Type of Service: _____ Deposit ☐ Yes ☐ No

Amount of Charge: \$ _____

Credit Card Number: _____

Credit Card Type: Check One ☐ VISA ☐ M/C ☐ AMEX ☐ DISCOVER

Expiration: _____

Security Code: VISA/MC (3 digits) _____ AMEX (4 digits) _____

Name of Credit Card Holder: _____

Billing Address of Credit Card: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Signature of Credit Card Holder: _____

Employee: _____

- A legible & valid copy of a state issued drivers license or government photo ID with credit card holder's signature must be attached.

My signature above indicates that I am approving the above related charges and that I may not cancel the authorization after my approval.

09/15