CREDIT CARD AUTHORIZATION

OFFICE INFORMATION:

DOCTOR NAME: DATE:

OFFICE ADDRESS:

BILLING OFFICE CONTACT:

BILLING EMAIL:

BILLING PHONE:

AUTO-PAY OPTIONS:

- ☐ Run credit card for each invoice
- ☐ Run credit card on last business day of each month
- ☐ Run credit card at the end of each week

STATEMENT DELIVERY OPTIONS:

- ☑ All statements will be delivered electrically to the billing email

CREDIT CARD INFORMATION:

☐ Master Card ☐ Visa ☐ American Express

NAME ON CARD:

BILLING ADDRESS:

CARD NUMBER:

EXPIRATION DATE: SECURITY CODE:

I AUTHORIZE REGULARLY SCHEDULED CHARGES TO MY CARD PER THE "AUTO-PAY OPTION" SELECTION ABOVE. I UNDERSTAND I WILL BE CHARGED THE FULL INVOICE OR STATEMENT BALANCE, DEPENDING ON THAT SELECTION, AND THAT THE CREDIT CARD CHARGE WILL APPEAR ON MY CREDIT CARD STATEMENT.

Invoices will be sent with each case and statements will be sent at the beginning of each month, reflecting the previous months invoices. A 2% per month late fee will be added to each outstanding balance exceeding 30 days. Past due accounts are subject to C.O.D.

SIGNATURE OF CARD HOLDER: DATE:

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