



Fax Authorization Payment Form

The information below is for the purpose of paying a balance or a deposit on my account. The information will be used solely for this purpose, and this purpose only. By signing below, I am giving authorization for payment in the amount listed on this form.

Patient Name: (please print)

First (patient)

Last (patient)

Balance due \$ _____

(Please initial)

Visa

Mastercard

Discover

Amex

Name as listed on Credit Card

Credit Card Number

Expiration date

Security Code

Billing Address

City

State

Zip Code

Patient Signature

Date

Authorized Signature for this account

Date