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Credit Card Authorization

This form is being provided for you to supply **West End Pediatrics, P.C.** the following information for **charges not paid at time of service.** Your signature authorizes us to deduct fees from the credit card. You must sign to authorize use of this credit card.
Verbal authorization cannot be accepted at any time.

Amount:

□ Pay balance in FULL

□ Do Not Exceed $ _____

I authorize **West End Pediatrics, P.C.** to maintain credit card payment information in our confidential files. I understand that this form is valid unless I cancel the authorization through written notice to the provider.

Credit Card Information:
We accept all major credit cards: VISA, MASTERCARD, DISCOVER, AMEX, DINERS.

_____

Patient Name(s)

_____

Cardholders Billing Address **City/State/Zip**

_____

Credit Card Account Number **Expiration Date**

_____

Security Code (back of card. Note: Front right for AMEX**)**

_____

Cardholders Name **Signature** **Date**