Patient Name:_____

Account:_____

Date:_____

CREDIT OR DEBIT CARD AUTHORIZATION INFORMATION

Billing Name:_____

Billing Address:_____

Credit Card #:_____

Exp.Date:_____ Verification#:_____

Monthly Billing Amount: $_____

Monthly Payments start:_____ 1st of month or 15th of month

Signature:_____

CHECKING ACCOUNT CREDIT AUTHORIZATION

Bank Name:_____

Bank Routing #:_____

Checking Acct.#:_____

Monthly billing Amount:$_____

Monthly payments start:_____1st of month or 15th of month

Signature:_____