Credit Card Authorization Form

Patient Name: ____

Name as it appears on card: ____

Billing Address:

____

____

Phone #: __________________________

Payment Information

Accepted payment Methods:

16 Digit Card Number:

____

Expiration Date (MM/YYYY): ___________________

3 Digit Security Code: _______
(On the back of the card in signature box)

4 Digit Amex Security Code: ________
(Last 4 digits on front of the card above ID)

I, ________________, hereby authorize the Center for Advanced Reproductive Medicine & Fertility to charge the above credit card in the amount of $ ___________. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: ____________________________________ Date: _________
(Authorized Credit Card Holder)

Signature: _____________________________________ Date: _________
Patient

2017 11 19 CC Auth form