Authorization for Credit Card on File Payment

Note: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION

Until further notice, I authorize Cardiovascular, Thoracic, and Vein Surgeons of Texas (Davis Vein & Vascular) to charge the patient-responsible balance(s) on my account to the following credit card:

Circle one: Visa MasterCard Discover Amex

Credit Card Number: _____

Exp. Date (mm/yy): _____/_____ CVV#: _____

Signature: _____ Date: _____ Printed

Name:

_____

Email Address:

_____

Patient Name: _____ DOB:
(If Different from Name on Credit Card) _____