Healthcare Partners
Family Medicine

CREDIT CARD PAYMENT AUTHORIZATION

Sign and complete this form to authorize the merchant below to make a one-time charge to your Credit Card listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for **a single transaction only** and does not provide authorization for any additional unrelated debits or credits to your account.

I, (print name) ____________________________________authorize Healthcare Partners Family Medicine to charge my Credit Card indicated below for $_________________ on ____________________________ (date).

Goods / Services rendered: Medical Treatment

Goods / Services rendered for:

☐ Self ☐ Other: _______________________________________ Date of Birth: ______________________

BILLING DETAILS

Billing address: ____

City: _______________________________ State: ___________________ Zip Code: ____________________

Phone# __________________________________ Email address: ___________________________________

CREDIT CARD INFORMATION

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder's Name: ___________________________________

Account Ending in (last 4 digit of Credit Card Number) : ________ Expiration Date: ____________________

Individual's Signature: ___________________________________ Date: _____________________________

*****ALL TREATMENTS ARE NON-REFUNDABLE*****