CREDIT CARD AUTHORIZATION FORM

I, _____, authorize GPM Pediatrics, PC to charge my credit card the amount stated below and to keep my credit card on file:

Patient Name:	Amount Paid:
Patient Date of Birth:	Patient Address:
Patient Account Number:	Date of Service:
Please check off form of payment: ☐ Mastercard ☐ Visa ☐ American Express ☐ Discover	Please complete ALL of the following information: Card Number:_____ Expiration Date:_____ Security Code: _____ Credit Card Zip Code: _____ Cardholder Name:_____ Signature:_____

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