CREDIT CARD AUTHORIZATION

I authorize Glendale Pediatrics to bill my Co-payment, Walk-in Charges and 60 day balance due to the credit card listed below. This authorization will automatically renew at the expiration date of the credit card and remain in force on each of my children's accounts until they are no longer patients of Glendale Pediatrics:

_____ _____

Credit Card Billing Address (Street Number) Billing Zip Code

VISA MC DIS Am Ex _____ _____ _____
Please circle Credit Card Account Number Exp Date CV
(Security Code)

_____ _____
Signature Date

_____ **(PLEASE PRINT LEGIBLY)**
Print Cardholder Name

_____ _____ ____/_____/____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ ____/_____/____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ ____/_____/____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ ____/_____/____
Patient's Last Name Patient's First Name Date of Birth

This information is kept on file in a secured location.