CREDIT CARD AUTHORIZATION

I authorize Glendale Pediatrics to bill my unpaid co-payment, work-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:

Please give your card to the Front Desk to be scanned into our secure system.

VISA MC DIS Am Ex _____ _____ _____

Please circle **Last 4 Digits** of Card Number Expiration Date CVV (Security Code)

_____ _____

Cardholder Signature Date

_____ _____

Print Cardholder Name Cardholder Email Address

_____ _____ ____/_____/____

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

_____ _____ ____/_____/____

Patient's Last Name Patient's First Name Date of Birth