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 my accounts until I am no longer a patient 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

This information is kept on file in a secured location.

Over 18 years