



CREDIT CARD AUTHORIZATION FORM

Date: _____

I Authorize Global Pediatrics to keep my signature on file and charge my credit card.

Name of Patient: _____

Chart Number: _____

Date of Service: _____

- **This Visit Only**
- **All Visits This Year**

Cardholder : _____

Cardholder Signature: _____

Credit Card #

MC: _____ **EXP:** _____ **CV#** _____

VISA: _____ **EXP:** _____ **CV#** _____

AMEX: _____ **EXP:** _____ **CV#** _____

TAKEN BY: _____