CREDIT CARD AUTHORIZATION FORM – Rachel Ross, M.D.

PLEASE PRINT CLEARLY

Name on Card _____
LAST FIRST MIDDLE

Address_____
STREET CITY STATE ZIP

I hereby authorize Rachel Ross, M.D., to charge my credit card for any outstanding balance not paid within one week after _____ (patient name)'s appointment.

Card Type: □ MasterCard □ Visa □ Discover □ American Express

Credit Card Number _____

Expiration Date _____

Verification Code _____ (last three digits on signature panel for most cards; four digits on front of AMEX card)

Billing Address: □ Same as above □ Different from above Address

_____
STREET CITY STATE ZIP

Phone Number Associated with Account _____

Signature _____ Date _____