Credit Card Authorization Form

Patient Name: _____ **Date of Birth:** _____

Name as it appears on card: _____

Billing Address:

_____

_____

Phone #: _____

Payment Information
Accepted payment Methods: VISA MASTERCARD

16 Digit Card Number: _____
Expiration Date (MM/YY): _____
3 Digit Security Code: _____
(On the back of the card in signature box)

I, _____, hereby authorize RMANJ to charge the above credit card in the amount of $ _____. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: _____ **Date:** _____
(Authorized Credit Card Holder)