# 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 RMA of PA 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)