

Credit/Debit Card on File

Date _____

I, _____, hereby authorize Westside Medical Associates of Los Angeles to bill any deductible, copayment, co-insurance, charges for non-covered services or balance due to my credit/debit card.

Account Number

Patient Name

Date of Birth

Type of Card (circle one)

VISA

MASTERCARD

AMEX

DEBIT

Name (as it appears on card)

Credit Card Account Number

CVV2 or CVC2 (3 or 4 digit code located on back of credit card)

Expiration Date

Signature

Date

This authorization will remain valid unless cancelled by written notice sent by certified mail to WMALA. We will mail receipt to the most current mailing address on file. All information will be kept confidential. Please notify us if there is any change in the status of the credit card provided. This notice will apply for all services rendered from the date of this notice onward.

