

Credit Card Authorization Form

Date:

I, _____, hereby authorize Dr. Lepor of Westside Medical Association to charge my credit card for any balance not covered by my Insurance Company. I agree to keep my card on file for future balances verbally approved by me.

() VISA () MasterCard () American Express () Discover

Credit Card Number: _____

Expiration Date: ____/____/____ VID Code: _____

Cardholder's Signature

____/____/____
Date

Please be assured that Westside Medical Associates will keep all information entered on this form strictly confidential.