Clearfield Medical Clinic

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Address:_____

Direct Telephone: (_____)_____-_____

I hereby affirm that I am the owner of the below referenced credit card and that my name is listed on the front of the credit card.

I hereby authorize Clearfield Medical Clinic to charge my credit card (listed below) for payment of goods and services. This Card will be kept on file and used to pay for services rendered at Clearfield Medical Clinic.

_____

Account Holder Signature

CREDIT CARD INFORMATION

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

Number:_____

Expiration Month:_____ Expiration Year:_____ Security Code: _____

Cardholder Signature X_____ Date___/___/___

Security Code:_____