Credit Card Payment Authorization Form

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Please fill this form out completely. **Payment must be at least $50**, per month.

Credit Card Number:

____

Expiration Date: ____/_____

I authorize Head & Neck Surgical Associates to keep my signature on file and to charge my payments to the credit/debit card selected above.

Amount to be charged: $_______

O Charge this amount on the ______ of each month --OR--
O Take this amount out weekly.
Starting on ___________.

Total balance to be paid: $________

Cardholder signature: ______________

Date: __________ Account #:________
Patient (print):_____________________