Flatiron Pediatrics
Port Washington

Credit Card Authorization Form

Date: ______________________________

I hereby authorize Flatiron Pediatrics to keep my signature on file and charge my credit card.

Name of Patient(s):

____

____

Credit Card (Please circle one.)   MC   Visa   Discover

Cardholder name: ____

Card # ____

Expires: ________/________ **CV#**______________
(3 digits on back)

CC mailing Address____

Cardholder Signature: ____