Flatiron Pediatrics

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27 East 22nd Street, New York, NY 10010

Credit Card Authorization Form

Date: _____

I 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_____
(Address & Zip)

Cardholder Signature: _____