Cohen & Sheinker MD PA

CREDIT CARD PROCESSING FORM

PATIENT NAME(S):

1. _____
2. _____
3. _____
4. _____

PARENT/LEGAL GUARDIAN'S NAME: _____

PLEASE CIRCLE ONE: AMEX / VISA / MC / DISCOVER

NAME ON CARD: _____

CREDIT CARD ACCT#: _____

EXP DATE: _____ /_____ **SEC CODE:** _____ **BILLING ZIP CODE:** _____

By signing below, I understand and authorize that if a balance remains on my account longer than 60 days, Cohen & Sheinker, MDPA may charge the full amount due to the credit card listed above.

SIGNATURE ON FILE: _____ **DATE:** _____