J&R Pediatrics

CREDIT/DEBIT CARD AUTHORIZATION FORM

CREDIT/DEBIT CARD INFORMATION (Visa, MasterCard, American Express, Discover)

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

By signing below, you authorize J&R pediatrics, PC to charge the credit or debit card as below for agreed purchase. I understand that my information will be saved for future transactions on my account.

Please type your name to sign below

Date

☐ I am the parent/guardian of this patient

X _____

Card type:

Cardholder's name (as shown on the card):

Card number:

Expiration date mm/yy

CVV (security) code

Cardholder ZIP code (from card billing address):