Credit Card Consent

Name on the card: _____

Type of Card: Visa _____ Mastercard _____

(We do not accept American Express or Discover. If you would like to pay with another credit card, please contact our office to see if we will accept).

Account number:_____

Expiration Date: _____/_____(mm/yyyy)

Security Code: _____(3-digit code on back of card)

Billing Address:_____

City, State, Zip:_____

Phone Number:_____

Date of Service: _____/_____/_____

Amount to be Charged_$_____._____

By signing this form, you authorize *Acorn Pediatrics* to charge your card for the amount listed above.

Signed:_____ Date: _____

Relationship to patient: □Parent □Guardian

□Other:_____