DESERT HEALTH CLINIC

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Phone (520) 396-4413 Fax (520) 396-4764

CREDIT CARD AUTHORIZATION FORM

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

CREDIT CARD INFORMATION
Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express ☐ Other _____
Cardholder name (As shown on card) _____
Card Number: _____
Expiration Date (mm/yy): _____ 3 Digit Security code (back of card): _____
Cardholder ZIP code (from credit card billing address): _____

I, _____, authorize Desert Health Clinic to charge my credit card above, for all balances due in my account. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Patient's signature. Date