EDMOND PSYCHIATRIC ASSOCIATES
2000 Sonoma Park Drive
Edmond, OK, 73013
Jennifer Morris, MD
Lyndsey Jones APRN, CNP Ashley Burns, APRN, CNP Sarah "Vaden" Danielson PA-C

CREDIT CARD AUTHORIZATION FORM

THIS FORM MUST BE COMPLETED ENTIRELY, DO NOT LEAVE BLANKS

Patient Name: _____

Your Name: _____

Relationship to Patient: _____

Credit Card Number: _____
(WE ONLY ACCEPT VISA OR MASTERCARD)

Expiration Date: ____/____/____ CV Number: _____

Complete Billing Address: _____

I understand that the credit card mentioned above will be used to pay the balance in full on this account.

Please choose one of the following:

___ I would like to be notified when you charge my card.

___by Phone - Phone Number _____
___by Mail

___ I do not want to be notified when you charge my card.

Signature: _____ Date: ___/___/___

Please include a legible copy of the front and back of your credit card and the front of your driver's license.

*** If you have questions please call our office ***