

J Lyndsey Jones APRN, CNP

Chester Hendershot, 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 ***

Phone: (405) 285-2260 ATTN: Amie Fax: (405) 285-2280