Georgemiller Whyte & Associates

# CREDIT CARD AUTHORIZATION

Patient Name: _____

Credit Card #: _____

V Code (last three digits on back of card): _____

Credit Card Type: MC _____ Visa _____ Discovery _____

Expiration Date: Month _____ Day _____ Year _____

Name as it appears on card (print): _____

Signature of cardholder: _____

Date: Month _____ Day _____ Year _____

Check all that apply:

☐ I authorize Georgemiller, Whyte & Associates, PC to process my credit card for balance due for services provided in excess of 90 (ninety) days.

☐ I authorize Georgemiller, Whyte & Associates, PC to process my credit card for all charges due for services rendered.

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