TYLER ORAL FACIAL SURGERY

CREDIT CARD AUTHORIZATION FORM

DATE _____

NAME ON CARD _____

CREDIT CARD TYPE _____

EXPIRATION DATE _____

CREDIT CARD ACCT # _____

THE NAME ON THE ABOVE CREDIT CARD MUST MATCH THE NAME OF THE PERSON AUTHORIZING CHARGES.

I, _____ (please print) authorize Tyler Oral & Facial Surgery to charge the above credit card for all services posted to the patients account listed below.

PATIENT NAME _____

Relationship to Patient _____

This authorization is valid until _____

_____
Cardholder's Signature

If card is not present you must include a copy of the above mentioned credit card – both front and back. A copy of photo ID must also accompany this form.