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 ______________________________

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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.

Where care has no boundaries