CREDIT CARD AUTHORIZATION FORM

We are pleased to provide you with a number of payment options. If you are interested in having your charges billed to your credit card on a monthly basis, please complete this form and return it to MPMS. You will be sent a statement on the 1st of the month detailing your charges. Your credit card will then be billed on the 10th of the month.

Name on Credit Card: _____

Practice Name: _____

Billing Address: _____

City: _____ State:_____ ZIP: _____

Please check one: __ Visa __ MasterCard __ American Express

Account Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____

CVV _____

I hereby authorize Medical Practice Management Services to processes charges reflected on my monthly invoice against my the credit card provided above. I realize that I will be provided a statement in advance of these charges being processed.

Signature: _____ Date : _____