

Credit Card Payment Authorization

By signing below, I authorize the office of Eddy OB/GYN, PLC to utilize my credit card information to pay towards my co-payments, co-insurance percentages and/or deductibles. This authorization is valid for as long as I am a patient of Eddy OB/GYN, PLC. I authorize amounts of \$50 or less to be deducted from my credit card on file. Any amounts due over \$50 will necessitate a call to me prior to the utilization of the card.

Name on Card _____

Type of Card Visa Mastercard Am Express Other _____

Card Number _____

Verification Code (3 digit code on back of card) ____ ____ ____

Card Expiration Date _____

Printed Name of Authorized Cardholder

Signature of Card Holder