

**COEM  
CREDIT CARD  
AUTHORIZATION FORM**

If you would like the Center to keep your credit card on file for payment on future services, please complete this form and return it to the front office personnel. Your authorization will be kept on file confidentially.

I authorize the Center for Occupational and Environmental Medicine to keep my signature on file and to charge my credit card account for services rendered.

Please circle one:

American Express      Discover

MasterCard              Visa

\_\_\_\_\_  
PATIENT NAME:

\_\_\_\_\_  
CARDHOLDER NAME:

\_\_\_\_\_  
BILLING ADDRESS of CARDHOLDER  
(please include home / apartment number)

\_\_\_\_\_  
BILLING ADDRESS LINE 2

\_\_\_\_\_  
CITY                      STATE              ZIP

\_\_\_\_\_  
CREDIT CARD A/C NUMBER

\_\_\_\_\_  
3 DIGIT CODE on back of care    EXP DATE

\_\_\_\_\_  
CARDHOLDER SIGNATURE