

CREDIT CARD AUTHORIZATION

I authorize Glendale Pediatrics to charge my unpaid co-payment, work-in charges, and 60-day balance due to the credit card listed below. This authorization will automatically renew at the expiration date of the credit card and remain in force on each of my children's accounts until they are no longer patients of Glendale Pediatrics:

VISA MC DIS Am Ex		
Please Circle		Last 4 Digits of Card Number
Cardholder Signature		Date
Print Cardholder Name		Cardholder Email Address / /
Patient's Last Name	Patient's First Name	Date of Birth
Patient's Last Name	Patient's First Name	Date of Birth
Patient's Last Name	Patient's First Name	Date of Birth
Patient's Last Name	Patient's First Name	Date of Birth
Patient's Last Name	Patient's First Name	Date of Birth