PSYCHIATRIC MEDICAL ASSOCIATES, P.A.

6404 INTERNATIONAL PARKWAY
SUITE 1010
PLANO, TEXAS 75093

(972) 267-1988
FAX (972) 267-3434

CREDIT CARD PAYMENT AUTHORIZATION FORM

DATE : _____

PATIENT NAME : _____

CREDIT CARD : VISA / MASTERCARD / DISCOVER
(CIRCLE ONE)

CREDIT CARD # _____

EXPIRATION DATE : _____

CVV # _____ (THREE DIGIT NUMBER ON BACK OF CARD)

AMOUNT : _____

NAME OF CARD HOLDER : _____

Payment plan instructions

_____

_____

_____

_____

CREDIT CARD HOLDER'S SIGNATURE : _____