Saumil Mehta MD PLLC
6404 International Pkwy, Suite # 1010,
Plano, TX 75093
Phone # 972-267-1988
Fax # 972-267-3434

CREDIT CARD PAYMENT AUTHORIZATION FORM

Patient Name :_____ D.O.B. _____

I hereby authorize Saumil Mehta MD PLLC to charge my credit card as per the credit card information and payment instructions given below.

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:

_____

_____

_____

_____

_____ _____ _____

Patient Name Patient Signature Date

Address: _____

Street City State Zip code

Signature of parent, guardian or authorized representative (if applicable) : Date