California Center for Reproductive Health

16550 Ventura Blvd., Suite 400, Encino, CA 91436

CREDIT CARD PROCESSING FORM

Patient Name: _____

Amount being applied to credit card: $_____   Date transaction will be processed: _____

Type of Credit Card:
- ☐ Visa
- ☐ Master Card
- ☐ Discover
- ☐ American Express

_____   _____ _____
Credit Card Number   Expiration Date   Security Number (3-4 digits)

_____
Credit Card Holder Name (as it appears on the card) (please print)

I authorize the above payment to be charged in full on the above transaction date:

_____
Signature of Credit Card Holder

☐ I authorize to have my credit card on file for future charges. I understand that my <u>credit card will not be charged without prior notification</u>. I reserve the right to remove my credit card from file.

Type of Credit Card (*if different from above*):
- ☐ Visa
- ☐ Master Card
- ☐ Discover
- ☐ American Express

_____   _____ _____
Credit Card Number   Expiration Date   Security Number (3-4 digits)

_____
Credit Card Holder Name (as it appears on the card) (please print)