TELEMED CREDIT CARD AUTHORIZATION FORM

ADD/ADHD Diagnostic & Treatment Center, PA

1524 Independence Parkway, Suite A-1

Plano, Texas 75075

972.943.0410

PATIENT NAME:_____ PATIENT DOB:___/____/___

Reason for payment: Telemed Appointment

Credit Card #: _____ (Visa / MC / Amex/Discover)
Exp Date: _____ Security Code: _____ (on back of card)
Billing Zip Code: _____

Signature _____Date:_____

TO BE FILLED OUT BY STAFF ONLY

Date Requested to Run CC: ____/____/____

Would patient/guardian like a copy of receipt? ☐ NO ☐ YES

If "Yes", do they want their copy? ☐ EMAILED ☐ MAILED

Keep card on file _____ Yes _____ No

STAFF INITIALS: _____