# 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 #: _____<br>(Visa / MC / Amex/Discover) |
| Exp Date: _____ Security Code: _____ (on back of card) |
| Billing Zip Code: _____ |

ADD/ADHD Diagnostic and Treatment Center is hereby authorized to charge the above credit card for amount due. All credit card information to be handled with strict confidentiality.

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: _____**