CAROLINA FOOT & ANKLE ASSOCIATES

Credit Card Authorizations Form

Please complete all fields. You may cancel this authorization at anytime by contacting our office. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐AMEX ☐Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):_____ Security Code_____
Cardholder ZIP Code (from credit card billing address):

I, _____ authorize Carolina Foot & Ankle Associates to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date