Credit Card Authorization Form

Patient Name: ____

Name as it appears on card: ____

Billing Address:

____

____

Phone #: ____

Payment Information

Accepted payment Methods:

16 Digit Card Number: ____

Expiration Date (MM/YYYY): ______________________

3 Digit Security Code: ________
(On the back of the card in signature box)

4 Digit Amex Security Code: _______________
(Last four digits on front of the card above ID)

I, _________________, hereby authorize RMA of NJ, LLC to charge the above credit card in the amount of $ _____________. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: ____ Date: ___________
(Authorized Credit Card Holder)

Signature: ____ Date: ___________
Patient

FFS982 9/15/2016