Credit Card Payment Authorization Form

Sign and complete this form to authorize **Dallas Orthopedic & Shoulder Institute** to make one time/ multiple debit(s) to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

Please complete the information below:

I _____ authorize **Dallas Orthopedic & Shoulder Institute** to charge my credit card
(full name)

account indicated below for _____ on or after _____ for one time / multiple debit(s).
(amount) (date)

This payment is for_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

For multiple debits, please check one:

____ Single Payment Of $_____, on (date) _____

_____ 3 Weekly payments of $_____, starting (date) _____

____ 3 Bi-Weekly payments of $_____, starting (date) _____

_____ 3 Monthly payment of $_____, starting (date) _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I also understand that this card may be used to settle any past due (>30 days) balance on my account in order to prevent being sent to collection agency. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form._____**(Initial here)**