TRI-VALLEY
MEDICAL CENTER, INC.

# *CREDIT CARD AUTHORIZATION*

**PLEASE CHECK ONE:**
**___VISA**
**___MasterCard**
**___American Express**

**DATE TODAY_____**

I the undersigned, authorize Tri-Valley Medical Center, Inc. to use the specified credit card as payment for the following charges:

Print Card Holder's NAME:_____

Card Holder's ADDRESS:_____

Card Holder's CITY STATE ZIP CODE_____

Company Name (if applicable)_____

Credit Card Number:_____

Credit Card Expiration Date_____

Card Holder's Signature_____
This authorization is for payment due for medical services :( Amounts due)
Copayment: Physician phone appt: Balance on account:
Services not covered by health insurance:

**x _____PAYMENT AUTHORIZED FOR AMOUNT**
Upon completion of this form, please fax it to 925-866-8802
Attn: Billing
Thank you,
Tri-Valley Medical Center, Inc.
1081 Market Place Ste 200
San Ramon, California 94583
Authorization Number (office Use Only) : _____