CREDIT CARD AUTHORIZATION FORM

DATE: _____

PATIENT ACCOUNT #: _____

PATIENT NAME: _____DATE OF BIRTH: _____

CARDHOLDER NAME: _____

EXPIRATION DATE: _____ CVV CODE: _____

BILLING ZIP CODE: _____

CARD TYPE: MASTERCARD_____ VISA ____ DISCOVER____ OTHER____

CARDHOLDER SIGNATURE: _____

I AUTHORIZE CONCIERGE HEARING DEVICES TO CHARGE THE ABOVE CREDIT CARD IN THE AMOUNT OF:

$ _____.00

PAYMENT AMOUNT ON THIS DATE: _____

PATIENT SIGNATURE: _____

STAFF SIGNATURE (AUD/HIS): _____

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