

ROY M. STEFANIK, DO
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AUTHORIZATION FOR CREDIT CARD USE

Patient Name

Credit Card Information

Visa Mastercard Discover American Express

Credit Card Number

Expiration Date

3 Digit Security Code

Card Holder's Name (as it appears on the card)

Credit Card Billing Address

Address Line 1

Address Line 2

City

State

Zip Code

I authorize Roy M. Stefanik, DO to use the credit card information above to manually charge my credit card for an appointment at the rate of my regular session.

Patient Signature

This signature denotes my agreement to the statement made above.

Date