pacific frontier
MEDICAL

CREDIT CARD AUTHORIZATION FORM

I, _____, authorize Pacific Frontier Medical, Inc to keep my credit card number and expiration date on file in my electronic medical chart. This will be kept in the confidential section, and is only accessible by the staff of Pacific Frontier Medical.

Patient Name: _____

Patient/Responsible Party Signature: _____

Date: _____

……

Please enter your information below. This section will be destroyed once your information is entered into you medical chart.

Credit Card Number: _____

Expiration Date: _____

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