Credit Card Payment Authorization Form

Sign and complete this form to authorize **Women's Healthcare of Kendall, LLC** to make a debit 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. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I, _____authorize **Women's Healthcare of Kendall, LLC** to charge my credit card account indicated below for the amount indicated below.

$_____ on or after _____.
(AMOUNT) (DATE)

This payment is for _____.
(DESCRIPTION OF SERVICES)

Billing Address _____ Phone: _____

City, State, Zip _____ Email _____

10700 North Kendall Drive
2nd Floor
Miami, FL 33176

P: 305.270.7999
F: 305.270.6788
www.womensmd.net

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) _____

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, for the amount indicated above only, and is valid for one time use only. 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.

SIGNATURE _____ DATE _____

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