iMed

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CREDIT CARD AUTHORIZATION FORM

The Undersigned permits and authorizes Maria I. Bermudez Fresse, M.D. (Preventive Medicine Associates, LLC, DBA iMed), to keep my credit card information and signature on file. I authorize the charging of my credit card for all fees for products and services incurred by the below named patient, now and in the future. Families with more than one patient in household: Please, complete one form for each family member.

Patient's Name: _____ Today's Date: _____

Patients Date of Birth: _____

(if additonal patients on the household, please print and attach an additional form)

These are the only types of cards we are able to process at this time.

Please circle one: (Visa / MasterCard / Discover / AmEx)

Name as it appears on your credit card: _____

Credit card number _____ Expiration Date _____

Verification Code (The last three digits on signature panel) _____

Billing Address

_____

_____

City_____

State _____ Zip code _____

Phone (_____) _____

Email _____

Name of Cardholder (as it appears on your credit card): _____

Signature of Cardholder: _____ Date: _____