

**AUTOPSY AND PATHOLOGY SERVICES, P.A.**

3007 WOODLAND HILLS DR. #123  
KINGWOOD, TEXAS 77339-1403

24 HOURS: (713) 200-0173

OFFICE: (281) 359-1953

FAX: (281) 657-6834

**CREDIT CARD FORM**

*(Please print as neatly as possible)*

AMOUNT CHARGED \$ \_\_\_\_\_

Card Type (circle one):    Visa    MasterCard    Discover    American Express

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

The back of your credit card may have a three digit security number located on or near the signature line. Please enter that three digit number here: \_\_\_\_\_.

Card holder name (please print) \_\_\_\_\_

Address where card holder receives their monthly credit card statements:

Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Zip code: \_\_\_\_\_

**I AGREE TO PAY ABOVE AMOUNT ACCORDING TO CARD ISSUER.**

Signature of Card Holder \_\_\_\_\_

Date signed: \_\_\_\_\_

**PLEASE WRITE NEATLY AND COMPLETE ALL LINES-DO NOT LEAVE ANY BLANKS!**