Premier Chronic Pain Care Dr.
Rasean T. Hodge
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Credit Card Authorization Form

Patient:_____ Amount to bill cc:_____

Cardholders Name:_____
(exactly as it appears on the credit card)

Phone Number: _____ Email: _____

Credit Card Type: ☐ MasterCard ☐ Visa ☐ ☐

Credit Card Number: _____ - _____ - _____ - _____ Security Code: _____

Expiration Date: ___ / _____

Billing Address: _____

City: _____ State: _____ Zip:_____

Cardholder Signature: _____ Date: _____