CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at anytime by contacting us, however we required credit card card information to remain on file for DPC membership.
This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard. ☐ VISA. ☐ Discover. ☐ Amex ☐ Other_____
Cardholder Name (as shown on card):
Card Number: _____. CVV (3 digit code back of card): _____
Expiration Date: (mm/yy):_____
Cardholder Zip Code (from credit card billing address):_____

☐ I hereby authorize use of this card the following family members.

Name and birth date:

1. _____
2. _____
3. _____

I, , authorize myNPoffice LLC to charge my credit card above for agreed upon healthcare charge. I understand that my information will be saved to file for future transactions on my account

Patient Signature: Date: