



Credit Card Authorization Form

****Signature below hereby authorizes Xpress Urgent Care to process CC for specified amount below. All information must be provided and emailed to us for processing****

CREDIT CARD INFORMATION			
Patient Name:			
Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> American Express <input type="checkbox"/> Discover			
Credit Card Number:			Expiration Date:
Name as it appears on Credit Card:			CVC2 Code:
Signature:		Date:	
CREDIT CARD BILLING ADDRESS			
Street Address:			
City:			
State:	Zip/Postal Code:		Country:
Phone Number:		Fax Number:	

Thank you!