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To Pay by Credit Card, Please Fill in Below:

Print exact name imprinted on credit card: _____

Card Number: _____

Card Expiration Date: _____ Security Code: _____

Billing address for card: _____

Print name if different from above: _____

Today's Date: _____

Would you like us to keep this card on file for future payments? (Please circle your answer)

YES NO

If yes, do you authorize us to run only your amount due automatically? (Please circle your answer)

YES NO

Need a receipt? We can email a copy to you.

Email address for receipt: _____

PLEASE NOTE THAT NAME ON YOUR CREDIT CARD STATEMENT WILL SHOW:
"MEDICAL BILLING CENTER"