AUTOMATIC CREDIT CARD BILLING AUTHORIZATION FORM

If you would like to enjoy the convenience of automatic billing, simply complete and sign this authorization form. All information is required. We will bill your credit card automatically for the amount indicated. You may cancel this automatic billing at any time by contacting us.

Customer Information:

Customer Name: ______________________________ Acct #: ______________

Address: ____

City: ______________________ State: __________ Zip: ____________

Cell Phone: ____________________ Work Phone: ____________________

Payment Information:

I authorize CREEKSIDE MEDICAL to automatically bill the card listed below as specified:

Amount: $ __________________ per month Starting on: __________________

Other Instructions: ____

End billing after ______________months **or** upon account paid in full.

Credit Card Information: (all fields are required)

Credit Card Type Visa MasterCard Discover

Card #: ______________________________Exp: ____________CVV:________

Card Holder Name: ____

Address on CC Statement: ______________________________________

City: ______________________ State: __________ Zip: ____________

Cardholders Signature: ______________________________Date: ____________

Fax this agreement without a cover sheet to 360-816-1327
Or mail to: CREEKSIDE Medical 900 NE 139th Street, Ste 202, Vancouver, WA 98685
If you have questions, please contact our office 360-566-9355