

BAYVIEW GENERAL MEDICINE

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AUTHORIZATION FOR CREDIT CARD PAYMENT

TO: DR.RICHARD BLANCHAR’S OFFICE AND /OR BAYVIEW GENERAL MEDICINE.

I _____ AUTHORIZE THE OFFICE TO USE MY
CARD HOLDERS NAME

CREDIT CARD FOR PAYMENT OF MEDICAL, SURGICAL, COSMETIC SERVICES, OR
OTHER SERVICES AND/OR COSTS THAT WERE RENDERED TO

PATIENT _____, ON _____. I UNDERSTAND THAT THIS
NAME OF PATIENT *DATE*

PAYMENT IS **NON- REFUNDABLE.** _____ (PLEASE INITIAL)

CREDIT CARD NUMBER _____

EXP DATE ____/____/____ CHARGE AMOUNT \$ _____

SECURITY CODE: _____

(3 DIGIT CODE ON BACK SIGNATURE
LINE FOR VISA/MC. FOUR DIGIT CODE
ON FRONT ABOVE CC# FOR AMERICAN
EXPRESS)

CARD HOLDERS SIGNATURE

____/____/____
DATE

**1. PLEASE FAX VALID DRIVERS LICENSE OR OTHER FEDERALLY ISSUED
IDENTIFICATION ONLY.**

2. A PHOTOCOPY OF FRONT AND BACK OF CREDIT CARD.

3. RUB PENCIL ACROSS PAPER OVER TOP OF FRONT OF CARD FOR IMPRINT.