



## Willamette Falls Pediatric Group

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### AUTHORIZATION TO PROCESS MONTHLY CHARGES ON CREDIT CARD

I, the undersigned, hereby authorize **Willamette Falls Pediatric Group** to process credit card charges in the amount of \$ \_\_\_\_\_ per month, on the \_\_\_\_\_ of each month, until the total existing balance of \$ \_\_\_\_\_ is paid in full for services provided.



Card Holder Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ Signature Code: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date Authorized: \_\_\_\_\_

Once this form is completed and signed, we will mail you a copy for your records.