DALLAS WOMEN'S HEALTHCARE SPECIALISTS PLLC

Credit Card Payment Authorization Form

Sign and complete this form to authorize DWHCS to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

Please complete the information below:

I _____ authorize DWHCS to charge my credit card
(full name/DOB)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.