Willamette Falls Pediatric Group
1510 Division Street Suite 280
Oregon City, OR 97045
T (503) 905.3400
F (503) 905.3399

AUTHORIZATION TO PROCESS MONTHLY CHARGES ON CREDIT CARD

I, the undersigned, herby 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.

❑ VISA ❑ MasterCard

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.