Credit Card Authorization Form

Please complete all fields.
You are authorizing Amarillo Medical Specialists LLP to charge your credit card $1.00 now, in order to validate your credit card and enter it in our files.

This will be credited to you at your appointment. If you do not keep your appointment, or do not provide two business days advance notice of cancellation, you are authorizing us to charge $100 as a no-show fee.

You may cancel this authorization at any time after your scheduled appointment by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ Security Code: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Amarillo Medical Specialists LLP to charge my credit card above for agreed upon services. I understand that there is a $100 no-show fee if I do not keep my new patient appointment, and, I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date