OBGYN
ULTRASOUND

A PROGRAM OF THE DELAWARE CENTER
FOR MATERNAL FETAL MEDICINE OF CHRISTIANA CARE

Credit Card Authorization Release Form

I hereby authorize, Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc., to charge my credit card account in the event that I fail to pay the balance on my account or set up a payment arrangement within 20 days of my first statement. DCMFM will always attempt to contact you via statement and/or phone call prior to charging your account.

Date: ______________________________

Patient Name: ______________________________ Patient DOB: ________________

Credit Card Billing Information (please print):

First Name ____

Last Name ____

Address ____

City ____

State ________________________ ZIP ________________________

Phone Day ________________________ Evening ________________________

Payment Information

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Account # ____ Exp. Date ________________

Cardholder's Name (please print):

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Cardholder's Signature ____