Crovetti Orthopaedics & Sports Medicine
2779 W Horizon Ridge Ste 200
Henderson, Nevada 89052
(702) 990-2290 Ph
(702) 932-8372 FAX

Credit Card Authorization Form

I, _____, herby authorize (COSM) to charge my credit card in the amount of $ _____.

☐ monthly ☐ weekly ☐ one time, payment in full.

Type of Card: ☐Visa ☐Mastercard ☐ DISCOVER

☐ American express ☐ CareCredit

Credit card #_____Expiration Date: _____

CVV2 (last 3 on back of card): _____

Name on card:_____

Patient:_____ Account # _____

Credit Card Billing Address

Street: _____

City: _____ State: _____

Zip Code: _____ Country: _____

Telephone: _____

Being the cardholder or authorized signer, by signing below I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize (COSM) to charge my credit card.

(PLEASE INCLUDE A COPY OF YOUR ID)

_____
Signature

Date: _____