Patient Credit Card Consent Form

I authorize Dr. David E. Condon, D.P.M. to charge my credit/debit card for the amount indicated below.

Not to exceed $_____

Monthly_____

One Time
Charge_____

Date(s) of Service____/____/____

I am aware that these charges will be processed via the Internet.

_____ _____
Cardholder Signature Date

Patient
Name_____Account #_____
Cardholder
Name_____

Cardholder
Address_____
City_____State_____Zip
Code_____

VISA___
MASTERCARD___
DISCOVER___

CREDIT CARD NUMBER:

_____

EXP. DATE:_____

Instructions for use of credit card form.  Please fill out the form fields and when complete, you can either mail to:

David E. Condon, D.P.M.
P.O. Box  10069
Truckee, CA, 96162

or fax to 530 587 4293

For any questions:  Call  530 5877790

Thank you