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