BROOKSIDE WOMENS MEDICAL CENTER
1902 S IH 35, Austin, Texas 78704 (512) 443-9595

Credit Card Authorization Form

I, _____, hereby irrevocably authorize Austin Women's Health Center to bill my credit card for (patient name) _____ as detailed below.

Please print all information clearly:

Card #: _____

Type: □ visa □mc □ disc □amex Exp date: _____ cvs #_____
(3digits on back of card)

Charge amount: _____

Cardholder name: _____

Address: _____

_____

Phone: _____

(please leave a number ***where we can immediately reach you***)

Cardholder Signature: _____

- Attach legible copies of: (*note: faxing darkens copies*)
  1. Front and back of credit card
  2. Drivers license or government issued photo identification

Important! **Payment is due before services are rendered.** Please make sure you are available at contact number you have listed. If the copies we receive are not legible we cannot process payment and you will need to make additional attempts to send the information. This may cause a delay in services or even the need to reschedule. Thank you.

Office Supervisor use only:

approval: □ yes □ no per _____ □ card holder receipt/approval notification per _____