



Credit Card Authorization Form

Patient Name: _____

Name as it appears on card: _____

Billing Address: _____

Phone #: _____

Payment Information

Accepted payment methods:   

16 Digit Card Number: _____

Expiration Date (mm/yyyy): _____

3 Digit Security Code: _____ (on back of card in signature box)

This authorizes Reproductive Medicine Associates of Michigan, PLC (RMA) to charge the credit card listed above for any balance due on my account that I do not pay in person at the time of a visit using this or any other acceptable form of payment. I understand that I will receive a printed itemized receipt of any charge made to my credit card. I understand RMA will destroy this document within 30 days after my balance is zero once I have been discharged from care or otherwise completed.

Signature: _____

Date: _____