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Credit Card *circle one* (Visa, MasterCard, American Express, Discover), HSA, Flex
Any payment over 500.00 will not be taken without card holder authorization

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Patient Name(s)	Address	
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Cardholder Name(s)	City/State/Zip	
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Card Number 1	Month / Year:	3-digit:
Circle one if Flex or HSA	Exp. Date	Code on back
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