



New York House Call Physicians™
YOUR DOCTOR IN THE FAMILY

CREDIT CARD INFORMATION

Patient Name: _____

CARD HOLDER INFORMATION:

Name of Card Holder (exactly as it appears on credit card):

First Name: _____

Middle Initial or Name (if applicable): _____

Last Name: _____

Billing Address: _____

City: _____

State: _____

Postal Code: _____

Country: _____

Email: _____

Telephone Number: _____

Type of Credit Card (Please check box): VISA MASTERCARD DISCOVER AMEX

Credit Card Number: _____

Credit Card Expiration Date: _____

Credit Card Verification Number: _____

[Note: "NY HOUSECALL" will appear on your credit card statement]

I authorize **New York House Call Physicians™** (DBA "Doctor in the Family") to charge my credit/debit card for medical services today & for future medical care.

Card Holder's Signature: _____

Today's Date: _____



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