



3341 WEST BEARSS AVENUE
TAMPA, FL 33618

WWW.WHOLISTICPEDS.COM

813-960-3415 PHONE
813-960-3465 FAX

AUTHORIZATION FORM FOR CREDIT CARD USE

The Undersigned permits and authorizes David S Berger, MD, PA, DBA: Wholistic Pediatrics, to keep my credit card information and signature on file. I authorize the charging of my credit card for all fees for products and services incurred by the below named patient, now and in the future.

Today's Date: _____

Patient Name: _____

Patients Date of Birth: _____

These are the only types of cards we accept. Please circle one: (Visa / MasterCard)

Credit card number _____ Expiration Date _____

Billing Address _____ City _____

State _____ Zip code _____ Phone (_____) _____

Verification Code (*The last three digits on signature panel*) _____

Name of Cardholder: _____

Signature of Cardholder: _____ Date: _____