West Georgia Cardiology

Credit Card Authorization Form

_____/_____/_____
Date

Patient Name: _____

Date of Birth: _____/_____/_____

Account No.: _____

I authorize West Georgia Cardiology (WGC) to charge my credit card in the amount of $_____ on the _____ of every month until my balance is paid in full.

_____ I understand if my account is forwarded to a collection agency, I will be responsible for a 35% collection fee in addition to my balance.

_____ I understand if payment cannot be obtained through the card number I have provided, there will be a $5.00 fee attached each time my card is ran through.

Please select a card type: Visa ☐ MasterCard ☐ American Express ☐

My card number is:

Expiration Date: _____/_____

The address where the above credit card statements are sent is as follows:

_____

I understand by choosing this option a receipt will be mailed to me. If the date falls on a Saturday, Sunday, or holiday, I understand my card will be charged the next business day. (NOTE: *By choosing this option, you will be given a 10% discount to your current past due balance*).

_____ _____/_____/_____
Signature Date

129 Bankhead Hwy ♥ Carrollton, GA 30117 ♥ Business Office: (678) 839-7290 ♥ Fax: (678) 839-7293