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CREDIT CARD PAYMENT FORM

PLEASE SUBMIT TO SECURE ACCOUNTING FAX: (516) 578-8408

TODAY'S DATE: _____

PATIENT INFORMATION

Patient Name: _____

Acct #: _____

Date of Service: _____

Address: _____

Zip Code: _____

Phone#: _____

Email: _____

Type of Credit Card: Visa Mastercard Discover Amex

Credit Card#: _____

Exp. Date: ____ / ____

CVV Code: _____

Name on Credit Card: _____

Address (if different than above) _____

Amount of Payment: \$ _____

Shipping: _____

Unstained: _____

Total: _____

Pay with PayPal:

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