VI. Credit Card on File Authorization

Please complete this form for ***All Worlds Health*** & ***Pediatrics, P.C.*** to keep your credit card information on file for cancellation/no-show fees. For your convenience, we can also charge visit fees on this card if you would prefer.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: Visa MasterCard American Express

Expiration Date: _____

Security Code: _____ (3 digit code on back, except AMEX 4 digits on front)

Billing Zip Code: _____

E-mail for invoices/receipts: _____

I, _____, authorize ***All Worlds Health.*** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature _____ Date: _____