

VIRGINIA PEDIATRIC GROUP, LTD.

CREDIT CARD PROCESSING FORM

Patient Name

Account No.

1 _____

2 _____

3 _____

Date(s) of Service: _____

Method of Payment: _____

Credit Card Account Number: _____

Exp. Date: _____

Charge Amount: \$ _____

Name on the Card: _____

Billing Address:

Line 1: _____

Line 2: _____

City: _____ **State:** _____ **Zip:** _____

Telephone No. _____