Hillcrest Medical Clinic

511 E. Manchester Blvd.
Inglewood, CA 90301
Phone (310) 672-9000 **Fax** (310) 672-9030

Credit Card Billing Authorization Form

Sign and complete this form to authorize **Hillcrest Medical Clinic** to debit to your credit card listed below for billing purposes. By signing this form you give us permission to debit your account for the agreed amount. This is permission to keep the following credit card information on file for any transaction associated with your account.

Please complete the information below:

I _____ authorize **Hillcrest Medical Clinic** to charge my credit card
(full name)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

_____.
(description of medical services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I hereby authorize Hillcrest Medical Clinic to charge the indicated credit card associated with my account. Including if necessary adjustment to any changes to my account. In order to cancel the billing process I'm required to contact Hillcrest Medical Clinic. I agree that if I have any questions regarding my account or service provided by Hillcrest Medical Clinic I will contact their office. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.