

LAMAR ROBINSON, M.D., P.A.
1929 RECORD CROSSING RD
DALLAS, TEXAS 75235
214-905-9090

CREDIT CARD AUTHORIZATION

In lieu of my credit card imprint, I, _____ authorize
Lamar Robinson, M.D., P.A., to charge my credit card:

Credit Card Type: _____

Acct. No: _____

Exp. Date: _____

Full Name on Card: _____

Amount to charge: _____

Purpose of charge: _____

Name of person payment is for: _____

Cardholders complete address: _____

Cardholders daytime phone: _____

By signing below, I acknowledge charges described herein. The credit card will be charged for either the full payment or deposit as required by the above terms. Extended payment provisions will apply as provided for by policy of the credit card company.

signature

date

Identification is required. Please provide photocopies of your driver's license and a copy of the front and back of the credit card to be charged. Please enlarge both if possible. Fax all information including this sheet to 800-338-1897 or 214-905-5025.