



Ear, Nose, & Throat Surgeons

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CREDIT CARD AUTHORIZATION

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Date of Birth: _____

Circle one: MasterCard Visa

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OR

Keep card # for all outstanding claims for 2007 _____

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I authorize the office of ENT for Children, P.A. to charge/or credit any outstanding balances on my account to the above credit/debit card. I understand that I will be mailed a receipt upon request after the card is charged.

I understand that this information will be held confidentially and in full compliance with all laws relating to the protection of patient information.

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