FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD
5086 North Elston Ave, Chicago, IL 60630 773-725-0200
659 West Washington Blvd, Chicago, IL 60661 312-707-8988
7845 South Cottage Grove Ave, Chicago, IL 60619 773-892-0102

Credit Card Authorization Form

FOR USE **ONLY** ON BALANCE DUE ACCOUNTS

Patient Information

Patient Name: _____

Credit Card Holder's Name: _____
(as it appears on the card)

Credit Card Holder's Address: _____

_____

Phone Number: (_____)_____-_____

Payment Information

Type of Credit Card: ____ Visa ____ MasterCard ____ Discover

16 Digit Card Number: _____

Expiration Date: (___/_____) 3 Digit Security Code: _____ (on back of card)

Payment Information

$_____.___ ____ One-Time Charge ____ Monthly ____Weekly

I authorize Family Planning Associates Medical Group, Ltd (FPA) to charge my personal credit card listed for the amount authorized above for the balance due on my account. I agree to pay the amount which has been explained above. I understand that Family Planning Associates Medical Group will not process this payment until this original form is signed and a copy of my picture ID is received by our facility.

Signature: _____ Date: ____/_____/_____

Please mail this completed form to: Family Planning Associates Medical Group
5086 N. Elston Ave
Chicago, IL 60630
Attn: Patient Accounts

____ I request for Family Planning Associates Medical Group to mail my receipt(s) to my billing address when my balance is zero.