



CREDIT CARD Payment Authorization Sheet

Date: <<Type Here>>

Patient Name: <<Type Here>>

TCMC Patient Account Number (4-digits): <<Type Here>>

Amount Authorized for Payment \$ <<Type Here>>

Paid by: (circle or bold one of the below)

VISA  MasterCard  Discover  American Express 

Card Number: <<Type Here>>

Credit Card Security Code (last 3 digits on back of card): <<Type Here>>

Expiration date: <<Type Here>>

Cardholder name: <<Type Here>>

Cardholder address: <<Type Here>>

Cardholder phone #: <<Type Here>>

Signature of Cardholder: _____

If completing via email, cardholder will be called for final verbal verification

Please email this form to jsaunders@unitedsurgical.com , or

Please fax this form to (817) 837-4610, or

Feel free to bring the form to Baylor Medical Center at Trophy Club, Business Office and Insurance Verification, 2850 State Highway 114 E, Trophy Club, TX 76262

Please call the Baylor Medical Center at Trophy Club Business Office with any questions regarding this form or payment options at (817) 837-4625. They will be happy to help you.

Thank you for your patronage!