HEALTHY TRAVELER
Preventative Travel Medicine
Since 1992

Credit Card Payment Authorization

HEALTHY TRAVELER®
1250 East Green Street
Suite 100
Pasadena • CA • 91106
T 626 • 584 • 1200
F 626 • 584 • 2900
healthytraveler@gmail.com

THIS FORM IS TO AUTHORIZED ANOTHER INDIVIDUAL TO CHARGE FOR MEDICAL SERVICES ON YOUR CREDIT CARD.

Please fax IN ADVANCE of arrival to our clinic at 626-584-2900 with a copy of your valid drivers license and copies of both front and back of your credit card. You may also email to healthytraveler@gmail.com

• FULL NAME OF PATIENT(S) YOU ARE AUTHORIZING PAYMENT FOR:

_____

• I AM AUTHORIZING THE FOLLOWING ITEMS (Please initial all that apply):

_____ ONE TIME CONSULTATION , IMMUNIZATION(S) AND ORAL MEDICATION ONLY
_____ ONE TIME CONSULTATION ONLY- NO IMMUNIZATIONS/ORAL MEDICATIONS
_____ DISPENSE ORAL MEDICATIONS ONLY
_____ ALLOW PURCHASES OF TRAVEL SUPPLIES AND ACCESSORIES
_____ RETURN VISIT FOR ADDITIONAL IMMUNIZATIONS -BOOSTER SHOT SERIES
_____ AUTHORIZATION VALID ONLY UNTIL MONTH _____ DAY _____ YEAR _____

• Do you want an email copy of the medical services rendered?

Your email address: _____

• CIRCLE ONE: Visa Master Card Discover

• Credit Card Number _____ EXP _____/_____

• THREE or FOUR DIGIT CV2 SECURITY CODE _____

• Name on Credit Card _____

• Card Billing Address _____

• City _____ State _____ ZIP CODE _____

• Cardholder's Phone Number: Area Code: _____ Number _____

With my signature below, I hereby authorized Healthy Traveler® - Community Medical to charge my credit card account listed above for the office visit and/or medical services rendered today for the patient(s) named above.

• **Cardholder's Signature**_____

• Today's Date _____/_____/_____

• Contact number if there is a problem: Area Code _____ Number _____

• Additional comments by cardholder _____

_____

ALL INFORMATION PROVIDED ABOVE ARE KEPT CONFIDENTIAL IN OUR OFFICE AND ARE NOT SHARED WITH ANYONE EXCEPT YOUR CREDIT CARD COMPANY.

 02.2012