



## Credit Card Consent

If you think you would like to use your Mastercard or Visa to make payments **by telephone**, please complete the following, which allows us to accept such payments.

I, \_\_\_\_\_ hereby authorize Acorn Pediatrics to charge a  
(please print)

payment to my credit card if I call to request this and provide:

- The type of credit card to be charged (Mastercard or Visa) and
- The expiration date on the card

Authorized Signature of Cardholder: \_\_\_\_\_

Date: \_\_\_\_\_