Weill Cornell Physician Organization
Weill Medical College of Cornell University

CREDIT CARD PAYMENT AUTHORIZATION FORM

Cardholder Fax Number:	[redacted]
Department Fax Number	
Department Contact:	ANNIE RAMOS
Date:	SEPT. 26, 2018

Please be advised that in order to process your payment request the following form must be completed thoroughly.

Please print clearly

I, EPSTEIN (CARDHOLDER LAST NAME), JEFFREY (CARDHOLDER FIRST NAME) authorize DARIUS PADUCH, MD (PROVIDER NAME) within WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY UROLOGY (DEPARTMENT NAME) to charge my AMERICAN EXPRESS (TYPE OF CREDIT CARD) credit card account number: [redacted] (CREDIT CARD ACCOUNT NUMBER)

with an expiration date 6/21 in the amount of $ _____ (DOLLAR AMOUNT)

for EPSTEIN (PATIENT'S LAST NAME), JEFFREY (FIRST NAME), SELF (RELATIONSHIP TO THE PATIENT, if other that card holder)

for IDX account/invoice number: _____ (TO BE ENTERED BY DEPARTMENT)

Please provide the CV2/AVS number that appears on the back of your credit card after account number 9049. *(Note: This number is required in order to process you payment)

Cardholder Signature: _____

Date: SEPT. 26, 2018

Cardholder Daytime Phone Number: [redacted]

Visa, MasterCard
* Last 3 digits on back of card on Authorization Signature Strip

American Express
* Last 4 digits on front, middle right hand side of card (not embossed)

For internal purposes only:

Select one: *Patient Receipts* *International Patients* *Corporate Health Physicals*

W.C.P.O. Finance Office

Credit Card Policy and Procedures