



**New York House Call Physicians™**  
YOUR DOCTOR IN THE FAMILY

**CREDIT CARD INFORMATION**

Patient Name: \_\_\_\_\_

**CARD HOLDER INFORMATION:**

Name of Card Holder (exactly as it appears on credit card):

First Name: \_\_\_\_\_

Middle Initial or Name (if applicable): \_\_\_\_\_

Last Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Type of Credit Card (Please check box):  VISA  MASTERCARD  DISCOVER  AMEX

Credit Card Number: \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_

Credit Card Verification Number: \_\_\_\_\_

[Note: "NY HOUSECALL" will appear on your credit card statement]

I authorize **New York House Call Physicians™** (DBA "Doctor in the Family") to charge my credit/debit card for medical services today & for future medical care.

Card Holder's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_



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