

**University Hospitals
Health System**

University Hospitals
of Cleveland

**CREDIT CARD PAYMENT AUTHORIZATION
FORM**

SELECT ONE

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CARD NUMBER: _____

CARD EXPIRATION DATE: ____/____

SECURITY NUMBER (3 or 4 digits on back of card): _____

CREDIT CARD CHARGE AMOUNT \$ _____ .00

CARDHOLDER NAME: _____

CARDHOLDER ADDRESS: _____

CARDHOLDER PHONE NUMBER: _____

***I AGREE TO PAY ABOVE TOTAL AMOUNT ACCORDING TO CARD
ISSUER AGREEMENT**

X _____ DATE: _____
CARDHOLDER SIGNATURE

THIS AREA MAY BE USED TO EMBOSS ACTUAL CREDIT CARD