DOCTOR INFORMATION

Name: _____
Address: _____
City/ST/Zip: _____
Phone: _____
Fax: _____
Email: _____
Dr. License #: _____

Statement Preference:
☐ Individual ☐ Corporate

Credit Card (If you want on file)
☐ Visa ☐ Mastercard
Card #: _____
Expiration Date: ___/___/___
Name on Card:_____
Billing Zip Code:_____
Charge Balance on CC:
☐ 1st of the month ☐ 15th of the month
☐ Dr. Office will call each month to authorize

Acct Authorization & Agreement
The undersigned agrees to the following:
• *Terms are net 15*
• *A Finance charge will be assessed on all past due accounts.*
• *In the event an account is not kept current, the Credit Card on file is authorized to be used to pay the balance; also, the* undersigned agrees to pay all costs of collection activities and *agrees for the hearing to be held in state of Oklahoma.*

Signed:_____
Date:_____