Howard County Direct Primary Care, LLC

CREDIT CARD CHARGE FORM

NAME (*please print name as shown on credit card*):

____

CREDIT CARD (*check one*):

MasterCard: _____ VISA: _____ Discover: _____

Credit Card Number: ____

Expiration Date: ____________________

Security Code: ___________________

I hereby authorize Howard County Direct Primary Care, LLC to charge the above credit card according to my membership election options (see Attachment B of the Physician-Patient Agreement)

Patient Name (if different from above, please print):

____

Patient Signature:

____

Date: _______________________________