FloridaHeart
AND VASCULAR

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AUTHORIZATION TO CHARGE CREDIT OR DEBIT CARD

PATIENT NAME: _____

PATIENT ACCT: _____

I AUTHORIZE FLORIDA HEART AND VASCULAR, LLC TO CHARGE MY

CREDIT/ DEBIT CARD IN THE AMOUNT OF $ _____ ON THE DATE OF

_____

CREDIT/DEBIT: AMX, DISCOVER, MC, VISA

CARD HOLDER NAME: _____

CARD NUMBER: _____

EXPIRATION: _____

SECURITY CODE: _____

EMAIL ADDRESS: _____