CREDIT CARD AUTHORIZATION

I, _____, hereby authorize William P. Adams, Jr., M.D. PA, to charge my account up to the amount below for services rendered in connection with my surgical procedure (s) performed by William P. Adams Jr. MD PA. Any amount in excess of this will require additional authorization.

$80.00	William P. Adams, Jr., M.D. PA

*****ALL FIELDS REQUIRED

Name as it appears on the card:			
Credit Card Type:			
Account Number:			
Expiration Date:			
3 Digit Security Code			
House Number:		Zip Code:	