

1st Choice Inc.

PAYMENT AUTHORIZATION FORM

To: **1stchoicemed.com** (Valleydale Services)

Fax to: **1-954-252-4713**

From (Patient Name): _____

Today's Date: ____/____/____

Credit Card Authorization

Credit Card Type: _____

Credit Card Number:

Name On Card: _____

Expiry Date: ____/____/____ CVV/CVC: _____

Billing Address: _____

Home Tel #: _____

Cell #: _____

E-Mail : _____

Authorized Signature: _____

I approve and authorize Valleydale Services to charge my credit card on the day of scheduling a consultation. No guarantee is implied that medication will be prescribed and any prescription(s) issued is totally at the attending physicians discretion over which we have no control.