Bowman Medical Group
9777 Wilshire Blvd., Suite 707, Beverly Hills, CA 90212
Office: 310-276-4003 Fax: 310-276-4073
Email: info@bowmanmedicalgroup.com

CREDIT/DEBIT CARD AUTHORIZATION FORM

Client Name: ____

Name on Card: ____

Cardholder's Phone Number: _______________________________________

Type of Card: (Visa, MC, Amex or Discover)

Credit Card ______________________

Debit Card _______________________

Flex Spending/HSA Card ___________

Credit Card Number: ____

Expiration Date: ___________ CVV #: ___________

I, ____________________________________, authorize Bowman Medical Group to bill my credit card for any ongoing balances on my account.

________________________________ ______________________

Signature of card holder Date