



Care2u Medical Services PLLC
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Credit Card Authorization Form – Direct Care

Date; ____/____/____

I, _____, as the Individual cardholder, hereby authorize this card to be used for the deposit required or monies due for services rendered.

Credit Card Information

Type of Card: [] VISA [] MASTERCARD [] DISCOVER

Name as it appears on the Card: _____

Credit Card Number ____ - ____ - ____ - ____ Expiration Date ____ / ____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Credit Card Billing Address

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Cardholder Signature: _____ Date: _____ / _____ f _____

I hereby authorize this card to be used for the future deposits and/or payments.

Please sign both places Once for initial authorization and for future

Sign to authorize future charges

Cardholder Signature: _____ Date: ____ / ____ / ____

Cardholder's Name: _____