One Time or Recurring Payment Authorization Form

Please print out and complete this authorization and return it to our office via email: accountsreceivable@psmnv.com or fax: (775) 885-0773.

Practice Name: _____

Cardholder Name: _____

Address: _____

_____

Customer's Signature: _____

Credit Card Information

Card Type: ☐ MasterCard ☐ Visa ☐ Am Ex **Frequency:** ☐ Once ☐ Monthly (SaaS fees)

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ **Billing Zip Code**: _____

Card Identification Number: (3 or 4 digits located on the credit card): _____

Amount to be Charged (one time) $_____ Amount to be charged (monthly) $_____

Start on: _____/_____/_____
Month Day Year

Notify me when my card has been charged via email: _____
Email Address

Fax or send the authorization to:

accountsreceivable@psmnv.com
318 N. Carson St., Ste 214 • Carson City, NV 89701 • U.S.A.
Phone: (775) 885-2211 • **Fax**: (775) 885-0773