DocRx | The Next Generation of Healthcare.

Provider Forms

Credit Card Authorization Form

Clinic Information

Clinic Name: ______________________ Date: ______________

Clinic A/P Contact Name: ______________________

Contact Phone: ______________ Contact Email: ______________

Clinic Street Address: ______________________

DocRx Rep Name(s): ______________________

Billing Information

Card Type: ☐ Mastercard ☐ VISA ☐ AMEX ☐ Other: ______________

Cardholder Name: ______________________

Card Number: ______________________

Expiration Date: ______________ (MM/YY) CVC: ______________

Card Billing Address: ______________________

City: ______________ State: __________ Zip: ______________

Authorization & Consent

I, ______________________, authorize DocRx, Inc. to charge my payment method(s) above for agreed upon purchases, plus any applicable credit card/convenience feed at their current rate(s).

____
Cardholder Signature (or authorized representative)

____
Date

877.362.7991
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DocRx