



Comprehensive OB/GYN, LLC
Modern Practice with Traditional Values

Date: _____

ACCOUNT# _____

I _____ authorize Comprehensive OB/GYN, LLC

To charge my credit card (MasterCard, Visa, American Express).

(Circle One)

Account number#

Exp# _____ CV# _____ each month \$ _____

On or after the _____ of each month until my balance is paid in full.

Start 1st Payment in the month of _____.

My balance is \$ _____.

Patient's Signature

Witness Signature

Witness Printed Name