COMPREHENSIVE OB/GYN, LLC

Modern Practice with Traditional Values

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*****Telemedicine Credit Card Agreement Form*******

Date:______________________________

I ____________________________________ authorize Comprehensive OB/GYN, LLC to
(Print Patient Name)

charge my credit card (MasterCard, Visa, American Express, Discover)
(Circle One)

Account number ______________________________________

Expiration date__________________ CV#___________

Zip code for billing address for the above card:_________________

$60.00 for my telemedicine visit on __________________.
(Date)

Comprehensive OB/GYN will keep this number on file for future telemedicine visits.

I understand this is a self-Pay Telemedicine visit and is not reimbursed by my medical insurance plan.

By signing below, I agree to the above agreement.

_____________________________ _________________________

Patient's Signature Witness Signature

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