GASTROENTEROLOGY CONSULTANTS, INC. AND

THE ENDOSCOPY CENTER AT GATEWAY

***OPTIONAL* – IF YOU WANT US TO KEEP YOUR CREDIT CARD INFORMATION ON FILE**

CREDIT CARD INFORMATION FOR FILE

PLEASE PRINT NAME

I, _____ authorize Gastroenterology Consultants, Inc. and The Endoscopy Center at Gateway to keep my credit card information on file and bill my credit card for balances due after verbal confirmation with me.

Credit Card: Visa MasterCard

Credit Card Number: _____

Expiration:_____

Authorized until_____please specify date or until cancellation.

Signature_____ Date_____

YOU WILL BE CONTACTED FOR VERBAL AUTHORIZATION PRIOR TO USING YOUR CREDIT CARD.

1/4/2010