



**Medical Records Service**

**Credit Card Payment Form**

THIS SECTION TO BE COMPLETED BY CARDHOLDER

Patient Name: \_\_\_\_\_

Quote #: \_\_\_\_\_ Amount on invoice: \$ \_\_\_\_\_  
(Please note that an additional 4% convenience fee will be charged when using this method of payment)

PLEASE PRINT

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

Type of Card: ( ) VISA ( ) Master Card

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax form AND copy of request to: Photo-Stat, LP at 972-399-0960  
or mail to: Photo-Stat, LP, 120 S. Briery St., Irving, TX 75060**