

# Lexington • Ob Gyn

## Credit Card Payment by Mail / Fax

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

Patient Account #: \_\_\_\_\_

Amount to be charged: \$ \_\_\_\_\_

I authorize that the unpaid balance be charged to my major credit card, as listed:

Payment Method:

- Visa  
 Mastercard

Account Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
MONTH DAY YEAR

V-code: \_\_\_\_\_ (3, 4 or 7 digit security code)

Credit Card Billing Address:

Street: \_\_\_\_\_

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

Cardholders Name: \_\_\_\_\_

Card Member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail to: Lexington OB/GYN, PC  
145 East 32<sup>nd</sup> Street, 11<sup>th</sup> Floor  
New York, NY 10016  
Attn: Financial Services

Fax: (212) 686-1920