Miles Frank, M.D., PLC
675 Peter Jefferson Parkway, Suite 130
Charlottesville, VA 22911
434.202.1279

Contract for Payment

I hereby authorize *Dr. Miles Frank, M.D., PLC* to charge my credit card for services rendered.

Patient Name: _____

Parent/Guardian (if a minor): _____

Credit Card: _____

Credit Card No.: _____

Expiration Date: _____

V-Code (3 digits on back of card): _____

Billing zip code: _____

_____ _____
Signature of Patient or Parent/Guardian of Minor Date