

Parke County Health Department

Credit/Debit Card Payment Authorization Form

The completion and signing of this form authorizes the Parke County Health Department use of the credit/debit card information listed below. The Parke County Health Department also has permission to debit the account for any fees due to applicant, including a 3% Convenience Fee, minimum \$1.00.

Please complete fully

I, _____ authorize the Parke County Health Department to charge my credit/debit card account in an amount due for licenses, permits, or vital record searches and/or certificates on or after _____.

Signature

I authorize the above named to charge the credit/debit card indicated in this authorization form according to the terms outlined above. This authorization is limited to one use. I certify that I am an authorized user of the aforementioned card. I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name: _____

Billing Address: _____ Phone: _____

City, State, Zip: _____ Email: _____

Office Use Only: _____

Authorization # _____ Initials: _____ Date: _____

Please Fill Out Card Information

Account Type (Circle One): Visa MasterCard Discover

Account Number: _____ Expiration Date: _____

Security Code (3 Digit): _____