HCMS
Harris County Medical Society

HARRIS COUNTY MEDICAL SOCIETY
CREDIT CARD PAYMENT FORM

Branch (circle one): Central East North Northwest Southeast Southwest Western

_____

Please Circle the type of Credit Card: Mastercard / Visa / Discover / AMEX

Total Amount Charged: $_____ ☐ $50 dues assessment for the year
(3 Ethics Branch Meetings)
☐ $40 guest fee per person, per meeting

Credit Card No._____ Exp. Date:_____

Name as appears on credit card:_____

Name of Attendee:_____

Signature:_____

Send Receipt to (if applicable):_____

FAX THIS FORM TO A SECURE FAX AT 713-528-0951

All credit card information is privileged and confidential and will not be duplicated or distributed in any way.

For HCMS purposes only: Physician ID#:_____

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