Patient Name ______________________ Acct. No. ______________ Today's Date ______________

Byetta Program Payment Method

Credit Card Information

Visa Mastercard AMEX Discover (circle one)

Card Number ____

Expiration Date ____________________

Name as it appears on card ______________________________________

Address Credit Card Bill is Sent to

Address 1 ____

Address 2 ____

City ______________________________ State _________ Zip ___________

I authorize Endocrine Metabolic Medical Center to charge the below credit card $95.00 (USD) at the beginning of each month that I participate in the ***Byetta Program***.

____ ________________________

Signed Date

____

Print Name