**Card on File: Authorization Form**

**Information to be completed by cardholder:**

The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice:

Patient’s Name:

Name as it Appears

on the Credit Card:

Type of Credit Card:  MasterCard  Visa  Discover  Amex

Last 4 Digits of Card:

Expiration Date:

I, authorize the above medical practice to process the above credit card as “Card on File”. I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

|  |  |
| --- | --- |
| Cardholder’s Signature | Date |