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