# Credit Card Authorization Form

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

Merchant Name _____

Patient Name _____

**Card Information**

Card Type ☐ Visa ☐ Discover ☐ MasterCard ☐ American Express

Cardholder Name (as it appears on the card) _____

Last 4 Digits of Card _____ Exp Date (MM/YYYY) _____

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. I may also revoke this form by submitting a written request to the medical practice.

Cardholder Signature _____ Date _____