

Credit Card Pre-Authorization Form

I authorize _____ to keep my signature on file and to
(Name of Provider's Office)

charge the credit card selected below for the following:

Balance remaining after claim (s) is (are) resolved not to exceed \$_____ for:

This consultation only

All consultations this calendar year

All consultations from _____ to _____
(date) (date)

Recurring charges of \$_____ to be charged every _____
(frequency)

From _____ to _____
(date) (date)

Charges for the following family members:

(authorized family member)

(authorized family member)

(authorized family member)

(authorized family member)

Check One:

Visa®

American Express®

MasterCard®

Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ Date: _____

