Card on File Authorization

The undersigned agrees and authorizes **[Practice Name]** to save the credit card(s) on file. The use of this form is optional and for your convenience.

PATIENT NAME

CARDHOLDER NAME (if different)

I authorize **[Practice Name]** to process credit card as "Card on File" and charge in accordance with the agreed upon payment plan between the practice and me (e.g. one time charge, monthly payment plan, etc). 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.

TYPED SIGNATURE OF CARDHOLDER

DATE (MM/DD/YYYY)

☐ I am the parent or guardian of this patient.