CREDIT CARD PRE-AUTHORIZATION FORM

I authorize _____ to keep my signature on
(Insert Name of Provider/Practice)
file and to 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 _____ *(date)* to _____ *(date)*

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

From _____ *(date)* to _____ *(date)*

☐ **Charges for the following family members:**

_____ *(authorized family member)*
_____ *(authorized family member)*
_____ *(authorized family member)*
_____ *(authorized family member)*

Check One:

☐ Visa®
☐ MasterCard®
☐ American Express®
☐ Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ **Date**: _____