Patient Name: _____

CREDIT CARD AUTHORIZATION FORM

We require a credit card to be placed on file. Cards are securely filed and will be used only for payment of co-pays, co-insurance, payments for service and no-show fees. This is to help us expedite the check-in and billing process.

TRICARE Prime and Active Duty Service Member will not be charged a co-pay but must still put card information for any no-show fees.

NOTE: If your card declines 2 times, we cannot schedule any further payments until your outstanding balance is paid in full.

I _____ authorize Family Care Center to charge my account to pay
(full name)

for services, co-payments, co-insurance or no-show fees.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

SIGNATURE _____ DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form per the terms outlined above. If the above noted payment date(s) fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that this authorization will remain in effect until I am discharged from care or I cancel it in writing whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company; so long as the transaction corresponds to the terms indicated in this form.