Card Holder Authorization for Credit Card Charges

Patient Information

Name of Patient: _____

Credit Card Information

First Name (as it appears on credit card): _____

Last Name (as it appears on credit card): _____

Relationship to Patient: _____

Credit Card Type ☐ **AmEx** ☐ **Discover** ☐ **MC** ☐ **Visa**

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____ **CCV Code:** _____

Credit Card Billing Address

Street/PO Box: _____

City: _____

State/Zipcode: _____

Billing Phone: _____

Acknowledgement

I authorize Alina M. Galliano-Pardo, M.D., P.A. to charge this credit/debit/HAS debit card for any and/or all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on the card provided and that the credit card number provided and signature below are the same as those on file with the credit card issuer.

_____ _____

Cardholder's Signature Date

_____

Printed Employee Name