CREDIT CARD AUTHORIZATION FORM

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN.

All information will remain confidential.

Name on Card: _____

Billing Address: _____

City State Zip Code_____

Credit Card Type: ____ Visa ____ Mastercard ____ Discover ____ Other

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (3 digits located on the back of the card)

I authorize **Elite Primary Care** to save the credit card on file and charge my card on file for the services rendered. I agree to pay all charges in accordance with the terms of my bank cardholder agreement, including any copays, coinsurance, deductibles, or charges for services not covered by my insurance.

Cardholder Name: _____

Signature: _____

Date: _____/_____/____