Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes medical practice to save the credit card indicated below on file.

Medical Practice: Melbourne Hand Center

Patient's Name:

Name as it Appears
on the Credit Card:

Type of Credit Card: MasterCard Visa Discover Amex

CARD #

CVV #: (3 or 4 digit code from back of card)

Expiration Date:

I, authorize the above medical practice to process the above credit card as "Card on File". 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.

Cardholder's Signature Date