



## Card on File: Authorization Form

### Information to be completed by cardholder:

The undersigned agrees and authorizes Melbourne Hand Center to save the credit card indicated below on file.

Patient's Name:

Name as it appears on the Credit Card:

Type of Credit Card: MasterCard      Visa      Discover      American Express

Card Number:

CVV Number (security code):

Expiration Date:

I, \_\_\_\_\_ authorize the above medical practice to process the above credit card as "Card on File" and charge the card for payments owed for services rendered. Prior to any charges submitted to the credit card, an email or mailed paper statement will be sent. I will have 14 days to correct inaccuracies or make other payment arrangements.

Cardholder's signature: \_\_\_\_\_