Credit Card Pre-Authorization Form

I authorize ASSOCIATES IN FAMILY MEDICINE to keep my signature on file and to charge the credit card selected below for the following:

☐ **Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:**

- ☐ This consultation only
- ☐ All consultations this calendar year
- ☐ All consultations from _____ to _____
  (date) (date)

☐ **Recurring charges of $_____ to be charged every _____**
(frequency)

- ☐ From _____ to _____
  (date) (date)

☐ **Charges for the following family members:**

_____ _____
(authorized family member) (authorized family member)

_____ _____
(authorized family member) (authorized family member)

Check One:

☐ Visa ☐ American Express ☐ MasterCard ☐ Discover Card

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

Cardholder Signature: _____ Date: _____

3 digit code _____ Amex 4 digit code _____