



Credit Card on File Authorization Form

Patient Information:

- Name: _____
- Address: _____
- City, State, ZIP: _____
- Phone Number: _____
- Email Address: _____

Cardholder Information:

- Name on Card: _____
- Billing Address: _____

- Card Type (circle one): Visa | MasterCard | AmEx | Discover
- Card Number: _____
- Expiration Date (MM/YY): _____
- CVV Code: _____

Authorization Details: I, the undersigned, authorize [Medical Office Name] to securely store my credit card information and charge it for the following purposes:

1. **Missed Appointments or Late Cancellation Fees** - In accordance with the office's cancellation policy, I understand that a fee may be charged for appointments canceled with insufficient notice.
2. **Copayments, Coinsurance, and Deductibles** - To cover out-of-pocket expenses as determined by my insurance provider.
3. **Outstanding Balances** - For balances not paid within 30 days of billing.

Terms and Conditions:

- I understand that my card information will be stored securely and will only be used for authorized charges as described above.
- I agree to notify the office immediately if my card information changes or if I wish to revoke this authorization.
- This authorization will remain in effect until I provide written notice of cancellation.

Acknowledgment and Signature: I certify that I am the authorized user of the credit card listed above and that I agree to the terms outlined in this form.

Signature: _____ Date: _____

Dedication Above and Beyond.

Richard Fox, MD, FACS | Akin Beckley, MD, PHD, FACS

Alpine Surgical | 4743 Arapahoe Avenue, Suite 102, Boulder, CO 80303 | T. 303.449.3642 | F. 303.440.7299

Boulder | Louisville | www.alpinesurgical.net