Card on File: Authorization Form

The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: Dermatology Physicians Group

Patient's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits 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 certified request to **Dermatology Physicians Group 2148 N Damen Ave Chicago IL, 60647.**

_____ _____

Cardholder's Signature Date