Card on File: Authorization Form

The undersigned agrees and authorizes medical practice to save the credit card indicated below on file.

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 credit card on file. **Billing Zip code** _____

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 ***after submitting insurance claims*** to **Dermatology Physicians Group 2148 N Damen Ave Chicago IL, 60647.**

_____ _____

Cardholder's Signature Date