



EPITOMEDICAL

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CREDIT CARD "SIGNATURE ON FILE" AUTHORIZATION FORM

EPITOMEDICAL is hereby authorized to maintain credit card payment information in their secure and confidential files. This form is being provided for you to supply EPITOMEDICAL with this information for an automatic payment option. Your signature authorizes us to review this information and deduct fees for professional services rendered (including but not limited to copays / deductibles / self-pay fees) from the credit card listed below.

PATIENT INFORMATION

Patient Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email Address: _____

CREDIT CARD INFORMATION

Credit Card Type: Visa Mastercard Discover American Express Other

Name as it Appears on Card: _____ Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Zip: _____

By signing this form, I give permission to EPITOMEDICAL to charge my above noted credit care for fees related to their professional services. If I am using a company credit card, I am signing as an authorized user. My signature below confirms my knowledge and acceptance of fees, terms and policies of EPITOMEDICAL. I understand and agree to accept responsibility for payment of any and all professional services rendered should my credit card deny all or part of these charges as it will then become solely my responsibility. I also understand that this authorization will remain in effect unless I cancel this authorization in writing. I agree to always keep my credit card information updated and valid.

Printed Name: _____

Authorized Signature: _____ Date: _____