EPITOMEDICAL

EPITOMEDICAL
8859 WEST FLAMINGO ROAD
LAS VEGAS, NEVADA 89147
P: 702 419 3482 F: 702 433 5410

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 NAME: _____

ADDRESS: _____

CITY / STATE / ZIP CODE: _____

PHONE (CELL / HOME): _____

EMAIL: _____

CREDIT CARD TYPE: ___VISA / ___MASTERCARD / ___DISCOVER / ___AMX / ___OTHER

NAME AS APPEARS ON CARD: _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____

SECURITY CODE: _____

ZIP CODE: _____

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: _____