Card on file: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorized medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: **Integrative Medical of Coppell**

Patient's name: _____

Name as it appears
On the Credit Card: _____

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

Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date (MM/YY): ___ / ___

I, _____ authorize the above medical practice to process the above credit card as "Card on File." The Card on File will be charged for in office and telemedicine visits after the appointment. 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 request to the medical practice at any time.

_____ _____

Cardholder's Signature Date