**Sample Credit Card Authorization Form**

At [Name of Practice], we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn’t cover and which you’re liable for. Without this authorization, we will need to add a billing fee of [$X] to your account to cover our cost of mailing you monthly statements. In addition, we’ll have to charge an "outstanding balance" fee of 1.5% of the total bill for each month that your bill remains unpaid.

Rest assured, we keep your credit card information confidential and secure! Also, we will make a charge to your card *only* after we have filed the claim and your insurer has processed it. This means that the insurance portion of the claim gets paid and posted to your account first, and then any remaining amount is charged to your card on file.

**I authorize [Name of Practice] to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

**☐ Amex ☐ Discover ☐ Mastercard ☐ Visa**

**Last 4 Digits of Credit Card Number: XXXX-XXXX-XXXX-\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**

**Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_**

**I (we), the undersigned, authorize and request [Name of Practice] to charge the above credit card for balances due that my insurance company identifies as my financial responsibility.**

**This authorization relates to all payments not covered by my insurance company for services provided to me by [Name of Practice].**

**This authorization will remain in effect until I (we) cancel it. To cancel, I (we) must give a 45-day notification in writing to [Name of Practice], and the account must be in good standing.**

**Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**