

1350 NW 138th St, Suite 200

Clive, Iowa 50325

Phone: 515-758-8300

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**Card on File: Authorization Form**

**Information to be completed by cardholder:**

The undersigned agrees and authorizes Integrated Psychiatry PLLC to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Patient’s Name:

Name as it Appears

on the Credit Card:

Type of Credit Card: [ ]  MasterCard [ ]  Visa [ ]  Discover [ ]  Amex

Last 4 Digits of Card:

Expiration Date:

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 request to Integrated Psychiatry PLLC.

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| --- | --- |
| Cardholder’s Signature | Date |