

**Credit Card Pre-Authorization Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned Patient/Cardholder hereby authorizes GRACE HEALTH SERVICES LLC, to obtain payment of fees for services from the Patient/Cardholder’s Credit Card account identified below.

GRACE HEALTH SERVICES LLC may charge the account to secure the patient’s appointment time, for any missed/late cancelled appointments (minimum of 48 hours cancellation notice is required), without requirement of the Patient/Cardholder’s signature for each payment. A receipt of the transaction will be mailed to the address provided by the Patient/Cardholder above.

 ☐ I authorize any balance to automatically be charged to this credit card.

Name on credit card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE ONE:** Visa MasterCard American Express Discover

CVV Number: (3 digits on back of card – AMEX (4 digits on front) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: (Month/Year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Cardholder Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Authorized Signor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this form, the Patient/Cardholder acknowledges and agrees as follows:**

§ This signed form is confidential and will be kept on file at GRACE HEALTH SERVICES LLC.

§ The Patient/Cardholder authorizes GRACE HEALTH SERVICES LLC to automatically charge the above-referenced Credit Card.

§ The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.

 § Credit Card payments will appear on your statement as GRACE HEALTH SERVICES LLC.

§ If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees that the charges are valid and agrees not to dispute said charges. § This authorization will remain valid for 12 months or until revoked in writing with 30 days notice of revocation.