Credit Card Pre-Authorization Form

I authorize Valleycare Gastroenterology Medical Group to keep my signature on file and to
(Name of Provider's Office)

charge the credit card selected below for the following:

☐ **Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:**

- ☐ This consultation only
- ☐ All consultations this calendar year
- ☐ All consultations from _____ (date) to _____ (date)

☐ **Recurring charges of $_____ to be charged every _____** (frequency)

- ☐ From _____ (date) to _____ (date)

☐ **Charges for the following family members:**

_____ (authorized family member)
_____ (authorized family member)

_____ (authorized family member)
_____ (authorized family member)

Check One:

☐ Visa®
☐ MasterCard®
☐ American Express®
☐ Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ **Date**: _____