# CREDIT CARD-ON-FILE AUTHORIZATION

I, _____, hereby authorize **Aspen Dermatology** to initiate payments from my credit/debit card with the financial institution identified by me on this form for payment of services provided by **Aspen Dermatology**.

_____ (initial) I understand that this authorization will remain in effect until I cancel it, and I agree to notify **Aspen Dermatology** of any changes in my account information or termination of this authorization at least 5 days prior to any further charges to my credit card. I certify that I am an authorized user of this credit card and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the term's indication in this authorization form.

**Signature:** _____ **Date:** _____

**CARD NUMBER:** _____

Expiration Date: _____ CVV code: _____

Card Holder's Printed Name: _____

Signature: _____ Date: _____

**Billing Address Associated with Card on File**

Patient Name: _____ Date of birth: _____

Card holder's relation to patient: _____

Billing Address: _____ Phone: _____

City, State, Zip: _____

Scanned date: _____ Staff initials: _____ System "Alert" added: _____