

**CREDIT CARD PAYMENT AUTHORIZATION FORM**

EASTBLUFF MEDICAL REQUIRES THAT A CREDIT CARD BE KEPT ON FILE FOR PAYMENT OF ANY COPAY OR BALANCE THAT MAY NOT BE COVERED BY YOUR HEALTH INSURANCE.

PATIENT NAME \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_

CARDHOLDER NAME \_\_\_\_\_

**PLEASE CHECK WHICH CARD TYPE**     VISA     AMERICAN EXPRESS     MASTERCARD     DISCOVER

**ADDRESS AS IT APPEARS  
ON CREDIT CARD STATEMENT** \_\_\_\_\_

STREET

CITY

STATE

ZIP CODE

**CREDIT CARD NUMBER** \_\_\_\_\_

**EXP. DATE** \_\_\_\_\_

(OR PROVIDE CARD TO FRONT DESK FOR SECURE ENTRY INTO OUR SYSTEM)

**PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE**

I acknowledge and authorize Eastbluff Medical to charge the above credit card account for any co-payment and/ charges not covered by my health insurance provider. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account. The above information is complete and correct.

\_\_\_\_\_  
CARDHOLDER SIGNATURE

\_\_\_\_\_  
DATE