CRESCENT Pain Relief

Card on File: Authorization Form

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

Name on Credit Card: _____

Visa / MasterCard / Discover / AMEX - please circle

Last 4 numbers of credit card: _____ Expiration Date: _____

CVV Code: _____

I, (name of card holder) _____, authorize Crescent Pain Relief 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 the medical practice.

Card Holder's Signature Today's Date

Witness Today's Date

Patient account for this card to be under for this cardholder.

Patient's Printed Name Date of Birth

Patient's Printed Name Date of Birth

Patient's Printed Name Date of Birth

Patient's Printed Name Date of Birth