Credit Card on File

Please print clearly and fill out the details below.

***Card Type: Visa [ ] MasterCard [ ] Discover [ ] American Express [ ]** (We do not accept Care Payment or Care Credit)

***Card Holder's Name:** _____

***Card No:** _____

***Expiration Date:** _____

***Cardholder's Mailing Address:** _____

_____

***Email (required for receipts):** _____

Spouse and/or other family members covered under this credit card:

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

I hereby authorize West Front Primary Care, PLLC to charge/refund the credit card provided for payment of charges/refunds to my account. I understand that it is my responsibility to have enough credit availability to cover any charges that I may incur. In the case the charge exceeds $200 we will give you a courtesy call prior to charging your credit card. West Front Primary Care cannot be held liable for any "over limit" fees you may incur. This authorization will be kept on file and I agree to update any information on this account. This form will remain in effect until the expiration of the credit card account. Applicants may revoke this authorization by submitting a written request to West Front Primary Care. A new form must be submitted if information such as the list of authorized users and/or the credit card account's number or expiration date is amended.

Accepted ☐ Declined ☐

***Card Holder's Signature:** _____ **Date:** _____