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moukdad MEDICAL

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CREDIT CARD ON FILE AUTHORIZATION FORM

Moukdad Medical offers the convenience of keeping a credit or debit card on file for payment of balances, co-pays and telehealth services.

All card information is stored securely in compliance with PCI standards.

PURPOSE

Keeping a card on file allows timely payment of any patient-responsible balances after your insurance has processed claims. Your card **will not be charged** until:

- Your insurance company has determined your responsibility for payment, or
- You have agreed to pay for services not covered by insurance, or
- A late-cancellation or no-show fee applies under our Financial Policy.

CARDHOLDER INFORMATION

Name on Card: _____

Billing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Last 4 Digits: _____ **Expiration (mm/yy):** _____ **CVV:** _____

PATIENT AUTHORIZATION

I authorize **Moukdad Medical** to charge my card for patient-responsible balances, co-pays, telehealth visits, and no-show fees, as applicable.

I understand that:

- I will receive a statement or receipt for any charge made to my card.
- This authorization will remain on file until I provide written notice to cancel it.
- I may update or revoke this authorization at any time by contacting Moukdad Medical.

Cardholder Signature: _____ **Date:** _____

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