# Credit Card on file Authorization

ROCKVILLE GYNECOLOGY, LLC

All information will remain confidential.

Patient Name: _____

Name on Card: _____

Billing Address: _____

(Including zip code) _____

Credit Card Type: _____ Visa _____ MasterCard (We do not accept Amex nor Discover)

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize **ROCKVILLE GYNECOLOGY** to charge the above credit card for payments owed to my account for services rendered at their office. I agree to update any information regarding my account. The above information is complete and correct to the best of my knowledge.

_____ _____ _____

**Print Name** (cardholder) **Signature** **Date**

* If you do not feel comfortable leaving your card on file, please provide one of the two alternative options below. Please be aware this is not negotiable and no further appointments may be scheduled until a card/alternative option is provided.

- € $50 Deposit- Paid at the time of visit and remains in the account as a credit.
- € $50 Prepaid Card- Must be provided at next visit or by phone.