Credit Card Authorization Form

By signing this form I authorize Jaffrey Eye Care to keep my card on file.

I understand that my card on file will be used for the following reasons:
-Copays, coinsurance, or deductible payments not collected at date of service.
-No Show, Missed Appointment, or Late Cancellation fees.
-Insurance discrepancies.
-Outstanding balances greater than 31 days.

I understand that the benefits of keeping a card on file include, but are not limited to:
-paying balances and copays conveniently.
-making payments automatically, avoiding late fees and/or collections.
-avoiding additional costs accrued by using checks, envelopes, and stamps.
-receiving payment receipts via email.

Payment reference:

Card Type

☐ Visa ☐ Mastercard ☐ Discover

Cardholder Name: ____________

Card Number: ____________

Expiration Date: ________________________

CVV (3 digit code on back of card): ____________

Billing Address: ____________

Email (for receipts): ____________

I authorize Jaffrey Eye Care to keep the credit card indicated in this authorization form on file. I certify that I am an authorized user of this credit card. I understand that the payment is non-refundable, except in cases of redetermination of payment by my insurance. I understand that this authorization does not prevent dispute of charges or questioning insurance determination of payment.

____ ________________________
Client Signature Date