XCEL
PRIMARY CARE

CREDIT CARD AUTHORIZATION

Patient's Name: _____

DOB: ____ / ____ / _____ Email: _____

I _____ (name of card owner) authorize XCEL PRIMARY CARE, PLLC to charge my credit card for any copay, deductible and co-insurance that I may owe for services rendered. In addition, I authorize XCEL PRIMARY CARE, PLLC to charge my credit card a $75 fee for cancellation of appointments not honoring the 24-hour cancellation policy, as well as for missed appointments. I will keep my credit card information with XCEL PRIMARY CARE, PLLC up-to-date. Also, I authorized XCEL PRIMARY CARE, PLLC to process any refunds to this credit card.

I will provide my credit card to the front desk.

Address (associated with card):

_____

_____

_____ _____

Authorized signature of cardholder Date