## Card on File: Authorization Form

I agree to allow Preston Dermatology and Skin Surgery Center, PA to charge my saved credit card for services provided by Preston Dermatology and Skin Surgery Center, PA.

I acknowledge that:

- My credit card will be stored by PayLeap, a secure credit card processor that partners with Preston Dermatology and Skin Surgery Center, PA to collect payments.
- I may cancel this agreement at any time by contacting Preston Dermatology and Skin Surgery Center, PA.
- I will contact Preston Dermatology and Skin Surgery Center, PA if there are any changes to my credit card information to include, but not limited to, card expiration, lost/stolen cards, credit limit reached, card reissue, or any additional reason that might affect proper processing of the card on file.
- I understand this authorization will remain in effect until the expiration of the credit card account.

Date: _________ Patient name: _____________________

Card Holder's Name: ____________________________________

Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ____________________________________

Please check and initial to decline this service: ___ ____

Cardholder Signature: ____________________________________