True Physician Care, LLC
10215 Fernwood Road, Suite 405
Bethesda, Maryland 20817

CARD ON FILE: AUTHORIZATION FORM

Information to be completed by cardholder:

The undersigned agrees and authorizes True Physician Care, LLC to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: True Physician Care, LLC

Patient's Name: ______________________________

Name as it Appears on the Credit Card: ______________________________

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐ ☐ ☐ ☐

Expiration Date: ______________

I, ______________________________ authorize True Physician Care, LLC to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. You may revoke this form at any time by submitting a written request to True Physician Care, LLC.

______________________________ ______________

Cardholder's Signature Date

301-941-3660 **truephysicancare.com** **949-440-7528**