



# Credit Card Pre-Authorization Form

I authorize Compass Oncology to keep my signature on file and to charge the credit card selected below for the following:

**Balance remaining after claim (s) is (are) resolved not to exceed \$\_\_\_\_\_ for:**

This consultation only

All consultations this calendar year

All consultations from \_\_\_\_\_ to \_\_\_\_\_

**Recurring charges of \$\_\_\_\_\_ to be charged every \_\_\_\_\_**  
(frequency)

From \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)

**Charges for the following family members:**

\_\_\_\_\_  
(authorized family member)

\_\_\_\_\_  
(authorized family member)

\_\_\_\_\_  
(authorized family member)

\_\_\_\_\_  
(authorized family member)

**Check One:**

Visa®

American Express®

MasterCard®

Discover Card®

Patient Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

