Trent C. Holmberg, M.D.

12481 S. Fort Street, Suite 275
Draper, Utah 84020

Authorization to Charge Credit Card

(owner of card must be the one to fill out form)

Credit Card Information:

Credit Card Number: _____Exp: _____

Name As It Appears On Card: _____

Zip Code Associated with Credit Card: _____ Security Code_____

I, _____ authorize Trent C. Holmberg, MD, PC to charge my credit card for the full amount of my visit or for the each visit of the patient listed below. My relationship to this patient is _____.

If the card listed on this form is not the patient's and the patient is over 18, the patient must also sign an authorization to release protected health information so that our office can release financial information such as receipts, statements or superbills for insurance reimbursement or tax purposes if requested. These financial documents may contain the patient's PHI (protected health information) such as the patients name, address, date of birth, the date and length of appointment, diagnosis and billing codes, etc. Please make sure the patient understands this before signing this form.

Payments will generally be processed on the same day of services, but could be a few days later. I further understand that my credit card will automatically be charged without prior notice for any missed appointments or late cancellations or if a form of payment is unavailable at the time of service. I understand that my credit card information will be kept safe and confidential and will only be accessed by authorized office staff when needed. I understand that it is my responsibility to keep my credit card information current and notify Dr. Holmberg's office if my credit card information changes or becomes invalid. I have the right to revoke this information at any time if I no longer wish to keep my credit card information on file. I acknowledge that I have read the above information and understand it completely.

Signature_____ Date: _____

Patient Name: _____ Date of Birth:_____

If Patient Is Over 18, Initial Below

_____ I, the card holder, have talked to the patient and the patient understands that as the one paying or their visits, I may need to request receipts, statements or superbills which may contain sensitive information such as their name, address, date of birth, date and length of appointment, diagnosis and billing codes, etc. The patient has also agreed to sign a release that allows me to obtain this information.