TREASURE COAST Primary Care

1980 SE Ocean Blvd. Stuart, FL 34996 • **772-678-7043**
www.tcprimarycare.com | Secure Fax: **772-403-2379**

Authorization for Credit Card Use

All information will remain confidential.
You must contact us to change/cancel this authorization.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (CVC): _____ (last 3 digits located on the back of the credit card)

No Show Appointments Fee: $ 50.00 (USD)

Virtual Visits (Tele-Medicine) Appointment Fee: $ 40.00 (USD)

I authorize **TREASURE COAST PRIMARY CARE** to charge the credit card listed above for all Virtual Visit Fees (Tele-Medicine) that I schedule with a Provider and NO SHOW fees for any virtual or in-office visit for which I fail to show or fail to give at least 24hrs advance notice. I agree to pay for the purchase(s) in accordance with the issuing bank cardholder agreement.

Cardholder Authorization – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____