WILLIAM EARL FOX, M.D.

675 Peter Jefferson Parkway

Suite 335

Charlottesville, VA 22911

CARD ON FILE AUTHORIZATION FORM

Patient's Name: ______________________________ Patient's D.O.B.: ________________________

Card Type (circle one): VISA MASTERCARD DISCOVER AMERICAN EXPRESS HEALTH SAVINGS ACCOUNT

Name on card: ______________________________

Billing Address: ______________________________

City and Zip code: ______________________________

Card Number: ______________________________

Expiration Date: ____________ CVV: ___________

I, ______________________________, understand that Dr. William E. Fox, MD does not participate with any insurance companies, including Medicare, and that the full cost of the appointments is to be paid by the responsible party listed on the Patient Registration Form. I authorize Dr. William E. Fox and/or the office manager, Rikki Nash, to credit/debit the above card information for each appointment at the time of the appointment. I understand that this card will be charged the full amount of any missed appointments and/or late cancellations. This authorization will remain in effect until the listed card expires or until I cancel.

Responsible Party Name (PRINT): ____

Responsible Party Name (SIGNATURE): ______________________________ Date: ____________