WILLIAM EARL FOX, M.D.

675 Peter Jefferson Parkway

Suite 335

Charlottesville, VA 22911

CREDIT CARD ON FILE AUTHORIZATION FORM

Patient's Legal Birth Name:_____ Patient's D.O.B.:_____

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

Name on card: _____

I, _____, understand that Dr. William E. Fox, MD does not participate with any insurance companies and that the full cost of the appointments are 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. To cancel, I must submit a written request to Dr. William E. Fox or the office manager, Rikki Nash. I understand that a new Credit Card on File Authorization Form must be completed if the listed card expires or to change the card on file.

Responsible Party Name (PRINT): _____

Responsible Party Name (SIGNATURE): _____ Date:_____