**Capital Medical Associates, P.C.**
**1640 Rhode Island Avenue, NW**
**Suite 800**
**Washington, DC 20036**
**202-822-6311 Fax202-822-6313**

# Required Credit Card Authorization Form to Hold Appointment

Patient Name: _____

Credit Card (circle one): Master Card Visa American Express

Credit Card Number: _____
(Only last 4 digits if given verbally over phone)

Expiration Date: _____

CVS Number (Security Code): _____

I authorize Capital Medical Associates, P.C. to charge the "No Show" fee in the event that I do not cancel my appointment at least 24 hours prior to my scheduled time or I fail to appear for the scheduled appointment.

_____
Patient Signature

**Please fax or email 48 hours prior to your scheduled appointment.**

**If this form is not received appointment will be canceled.**