CREDIT CARD PRE-AUTHORIZATION

Please provide us with a credit card to put on file for your convenience and to avoid any future balances that may accrue due to deductibles, co-insurance, copay's, or any other fees for services. Credit card will not be charged (except as indicated below) unless approved by the patient or statements are not paid by the due date to avoid going to collections.

Please check to indicate the types of charges which you grant us permission to make against this or future cards on file:

_________ Routine co-payments

_________ Deductible payments

_________ Missed appointment charges (Not covered by HSA/FSA)

_________ Prescription charges (Not covered by HSA/FSA)

_________ Report charges (Not covered by HSA/FSA)

Declined Credit Card Charge: If your card is declined for any reason, you will be charged a $15.00 fee. This is to defray the resulting bank fees and costs associated with follow-up billing.

I, ____, authorize charges to my credit card for payment for those charges which I have authorized above.

Type of credit card: _____________________________ [Debit, Credit, HSA/FSA] (circle one)

Credit card number: ___________-____________-____________-____________

Expiration Date ________ / ________ Zip code:__________________________

CW2 Code: _____________ (3 digit code on back of card in signature strip)

____ ________________________
Signature Date Signed

____
Relationship to patient