

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