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CREDIT CARD AUTHORIZATION

For your convenience, you may provide us with your Visa or MasterCard credit card number, expiration date, and CW2 code, with which we will submit your charges for payment. Your credit card information will be kept securely. You can revoke this authorization at any time if you choose to use this service.

Please initial to indicate the types of charges which you grant us permission to make against your card:

_________ Routine co-payments

_________ Deductible payments

_________ Missed appointment 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 Dr. Brian C. Hocking to submit my credit card for payment for those charges which I have authorized above.

Type card(check all that apply): ___Visa ___MasterCard___Credit___Debit___HSA/FSA

Credit card number: ________-_________-_________-_________

Expiration Date _______ / ________

Billing Address House Number: _________ Zip code: _________

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

____ __________________________
Signature Date Signed

____
Relationship to patient

Last updated: August 2014