CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payments, co-insurance, deductible, or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME:_____

NAME, AS IT APPEARS ON CREDIT CARD:_____

BILLINGADDRESS:_____

_____

_____

EMAIL ADDRESS:_____

DISC/MC/VISA CARD#_____

EXPIRATION DATE:_____/_____ **VERIFICATION CODE (3 OR 4 DIGITS)**_____

I acknowledge and authorized the Foot and Ankle Care Center, Inc. to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 60 days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I provided to this office. If I am an uninsured patient I authorized payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date