Credit Card Payment Form

Patient Name _____

Billing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Pager _____ Cell Phone _____

Employer _____ Insurance Carrier _____

I authorized **[BHAGWAT PATEL M.D.,P.A]** to keep my signature on file and to apply charges to the credit card listed below for balance of charges not paid for by insurance and not to exceed $_____ for:

ˆ UNPAID BALANCES FROM _____TO _____.

ˆAll visits this calendar year

ˆ Recurring charges for ongoing treatment of $_____ from **[ ]** to **[ ]**

I assign my insurance benefits to the provider listed above. I understand that this authorization is valid for one year unless I cancel through written notice.

Type of credit card: ˆ Visa ˆ MasterCard
ˆ American Express ˆ Discover

Name as it appears on the card _____

Card number _____ Expiration date _____

Patient signature _____ Date _____