

## Credit Card Payment Form

Patient Name \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
Employer \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

I authorize **Brandon Gynecology Associates, PA** to keep my signature on file and to apply charges to the credit card listed below for the balance of charges that my insurance company does not pay and not to exceed \$ \_\_\_\_\_

For:

- This visit only  
 All visits this calendar year  
 Recurring charges for ongoing treatment of \$ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
(Insert Date) (Insert Date)

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

Type of credit card  Visa  MasterCard  American Express  Discover

Name as it appears on card \_\_\_\_\_

Card number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_