Brandon Gynecology
ASSOCIATES, PA

Compassionate Care for Women

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 _____ (Insert Date) to _____ (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 _____

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