

## **Credit Card Authorization Form**

Patient Name: \_\_\_\_\_\_ DOB:\_\_\_\_\_

Patient Signature	Date	Staff Signature	Date
Acknowledged, Agreed, & Accepted consent for my credit card to be ch		my signature below acknowledges t isted above.	hat I give my authorization and
office from your insurance company	your credit card will be c . If you would like your ba	I that as soon as your EOB (explanation harged for the balance due on your allance charged to a different card or i	account. As a courtesy we will text
with you personally. In conjunction	with HIPAA regulations, al	nstances will AAS charge your credit Il credit card information will be conf staff will be able to access this inform	idential and securely kept within
	will receive ONE statemer	ard authorization form you will be recont for any remaining balances. If the lent.	
Self-Pay Patients: If you are a self-paperformed.	ay patient without insuran	nce, AAS reserves the right to charge	the credit card on file for services
Returned Payment Fee: If we receiv card on file a \$40 returned paymen		s returned to us for any reason, AAS r	eserves the right to charge the
reschedule, AAS reserves the right t	o charge the credit card o	opointment in the office without a 48 on file a \$25.00 fee. If a patient misses the right to charge the credit card	s a scheduled surgery appointment
coinsurance, deductibles and any pa	atient responsibility as dire	arge the credit card on file for all pat ected from your insurance company. ged for all current patient balances o	A receipt will be sent to you for all
		urgeons to retain a valid credit card r authorized staff. Your credit card will	