SUMMIT CLINICAL SERVICES PC
USE OF CREDIT CARD – AUTHORIZATION

As a cost and time saving measure for our patients, providers, and staff, we have implemented a convenient way for you to settle any balance due on your account.

I authorize Summit Clinical Services to process payments on my credit card for services and fees at Summit Clinical Services PC, which may include co-payments, co-insurances, deductibles, account balances, missed appointment/no show/late cancellations, phone calls/conversations, service fees, non-insurance-plan covered services, and other amounts owed.

I understand that I may opt to pay by cash, check, or defer to the credit card on file. I also understand that I may revoke my credit card on file agreement in writing to the Summit Clinical Services PC Office Manager.

This information as well as my signature will serve as my authorization for Summit Clinical Services to charge my credit card for any balance determined to be my responsibility.

Information is maintained strictly confidential, and best practices are used to keep it secure.

Card Type (circle one): Visa Mastercard Discover

CARD HOLDER INFORMATION:

Full Printed Name on Credit Card: _____

Credit Card Billing Address: _____ City: _____ State: ____

Billing Zip Code _____

Full Card Number: _____ _____ _____ _____

Expiration: _____ / _____ 3-digit Security Code: _____

Cardholder Signature: _____ Today's Date: _____/_____/_____

PLEASE PRINT NAME AND BIRTHDATE FOR ALL PATIENTS (INCLUDING YOURSELF) UTILIZING THIS CREDIT CARD ACCOUNT:

Name: _____ Birth Date: ____/ _____/ _____

Name: _____ Birth Date: ____/ _____/ _____

Name: _____ Birth Date: ____/ _____/ _____

Name: _____ Birth Date: ____/ _____/ _____

EMAIL ADDRESS : _____