Summit Clinical Services PC
1761 S Naperville Rd, Suite 200 - Wheaton, IL 60189
Phone: (630)260-0606

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover
Cardholder Name (as shown on card): _____
Card Number: _____ _____ _____ _____
Credit Card Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Summit Clinical Services PC to charge my credit card above for agreed upon purchases (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), for the person/persons listed below**. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer/Cardholder Signature Date

Billing Email Address: _____

** Patient Name / Date of Birth : _____

** Patient Name / Date of Birth : _____

**Patient Name / Date of Birth : _____