Athans and Associates, Ltd.
32 Main Street, Park Ridge, IL 60068-4060
Tel: (847) 823-4444 Fax: (847) 823-4456

#4/5

Payment Authorization

For your convenience, and to guarantee payment for services rendered, we require documentation of a major credit card.

I authorize Michael J. Athans, Ph.D. and Associates, Ltd. to keep my signature on file and to charge my credit card account listed below for copays/coinsurance not collected at time of service, and for any current outstanding account balances following insurance determination.

I understand that this authorization is valid until I cancel the authorization through written notice to the health care provider or unless otherwise indicated.

AmEx ___ MasterCard ___ Visa ___ Discover ___ Credit ___ Debit ___

Account Number |___|___|___|___| |___|___|___|___| |___|___|___|___| |___|___|___|___|

Expiration Date |___|___|___|___| **CVV2** |__|__|__|__| MC/Visa: 3 digits on back of card
mo **yr** AmEX: 4 digits front upper right

Patient Name

_____

Card Member Name

_____

Card Member Billing **Address**

_____

City State **Zip**

_____

Card Member Signature Date

Office Use

Co-Pay: