

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.

Please note: Credit card charges may not coincide with scheduled appointment dates.

AmEx ___	MasterCard ___	Visa ___	Discover ___	Credit ___	Debit ___
Account Number	_ _ _ _	_ _ _ _	_ _ _ _	_ _ _ _	_ _ _ _
Expiration Date	_ _ _ _	CVV2 _ _ _ _	MC/Visa: 3 digits on back of card AmEX: 4 digits front upper right		
	Mo	Yr			

Patient Name		

Card Member Name		

Card Member Billing Address		

City	State	Zip
_____	_____	_____
Card Member Signature	Date	
_____	_____	