Pre-Authorized Health Care Form

I authorize ____
(name of health care provider)

to keep my signature on file and charge my account for balance of charges not paid by insurance within 90 days.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Patient Name: ____

Cardholder Name: ____

Cardholder Address: ____

City:____ State:__________ Zip: ____

Credit Card Number: ______________________________ Expiration Date: ____________

Cardholder Signature: _________________________________ Date: _______________

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