Financial Agreement

If **Yes**, your insurance company will be billed for applicable charges for today's service. By signing this form, you agree that any remaining balance due is the authorized signer's responsibility and will be charged to your credit card.

☐ **Yes** ☐ **No** (If **No**, Skip to Payment Authorization)

Payment Authorization

I Authorize _____(Office Name)
to keep my signature and charge my account below:

☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

☐ Balance of charges not covered/paid for by insurance for (check one):

☐ Total remaining balance of $_____

☐ Or up to $_____ with remaining balance in installment payments

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☐ Installment Payments/Recurring Charges

I/we,_____ (authorized signer) , hereby authorize _____(name of practice) to charge_____on a_____ (monthly/weekly/other) basis, starting on_____ (date) to the account number_____

Name on Card_____Exp date_____

CVC_____ Address_____ Zip_____

X_____ _____

Cardholder Signature Date

Office Notes: