Patient Payment Consent Form

Patient Name ____
Print Last *First* *Middle Initial*

Name on Card if different ______________________________________

I authorize _________________________________ **and ProfessionalCharges.com**,
Provider Name

to charge my credit card for professional services as follows:

Initial

_______ This visit only, for the amount of $ _____________ .

_______ All visits in the next 12 months, beginning _____ /_____ /_____,
not to exceed $ ___________ total.

_______ Recurring charges, date(s) of service _____ /_____ /_____ to
_____ **/**_____ **/**_____, not to exceed $ _______________,
____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

_______ **To charges my credit card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card: ____ Visa, ____ MasterCard, ____ Discover. D V V Number: _________

Card Number _______ - _______ - _______ - _______, Expiration Date ___________

Card Holder's Billing Address for Credit Card Statements

____
Street *City* *State* *Zip*

Card Holder Signature _________________________________, Date ____ /_____ /____

Charges will appear on your credit card statement as ***ProfessionalCharges.com.***

ProfessionalCharges.com
3429 Ocean View Blvd., Ste. K
Glendale, CA 91208
Phone: (818) 240-8295