PREMIER
PAIN & SPINE

Authorization for Credit Card/HSA Card on File

I, _____, authorize Premier Pain & Spine (PPS) to charge my credit card/HSA card for any outstanding balances AFTER applicable insurance reimbursements have been applied for medical services received at PPS.

Copays are due at time of service provided.

If the balance, after insurance benefits are applied, exceeds $100.00

you will receive a courtesy call prior to charging.

Type of card: _____MasterCard _____Visa _____ Discover _____ American Express

Full Name on Card: _____ Billing Zip Code: _____

Account Number: __ __ __ __ / __ __ __ __ / __ __ __ __ /__ __ __ __

Expiration date: ____ /____ CV code (3 digits on the back on card): _____

Signature of card holder: _____

Date: _____

Your information will remain confidential.

Would you like your receipt mailed? ____ Yes ____ No

Thank you for choosing Premier Pain & Spine