<u>Credit Card Pre-Authorization Form</u>

I authorize Valleycare Gastroenterology Medical Group, Inc. to keep my signature on file and to charge the credit card selected below for the following:

Balance remaining after claim(s) is (are) resolved that show patient responsibility balance for:

- Office visits
- Procedures
- Hospital charges for Dr. Wolfe/Physician Assistant billed from our office

Balance can be set up on a <u>Payment Plan Option</u> for a period of 90 days with approval from Office Manager.

Please list family members, other than yourself, that you want this Authorization to also cover:

______________________________	______________________________
(Authorized family member/relationship)	(Authorized family member/relationship)

CREDIT CARD INFORMATION:

Patient Name: ____

Cardholder Name: ____

Cardholder Address: ____

City: ____________________ State: __________ Zip: _________________

Credit Card Number: ____________________________ Exp Date: ____________

Cardholder Signature:________________________________Date:__________

Your **signature** is valid for one (1) year from the date above. You may cancel this signed <u>AUTHORIZATION in writing</u> at any time within the year it is valid.