CARDIOVASCULAR CONSULTANTS P.C.

www.cardiovascularconsultantspc.com

Date:_____

Credit card authorization form.

I authorize Cardiovascular Consultants, PC to charge against my credit card for any balance due after my insurance company has processed my claim. These balances will be my copay, deductible or coinsurance that my insurance has processed as my financial responsibility.

Cardiovascular Consultants, PC will only run my credit card if my balance is not paid within 90 days.

Cardiovascular Consultants, PC will mail processed receipt to me.

Patient name:_____

Signature_____

Patient account number:_____

37771 Schoenherr Rd, Suite 101 - Sterling Heights, MI 48312-2302 - Telephone (586) 698-1200 Fax (586) 275-3005
57850 Van Dyke Rd, Suite 400 - Washington, MI 48094-3826 - Telephone (586) 677-4606 Fax (586) 677-4661
75 Barclay Circle – Rochesters, MI 48307-1871 - Telephone (586) 698-1200 Fax (586) 698-1210

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Credit Card Form

Date:_____

Patient Name:_____

Patient Account Number:_____

Credit card holder name:_____

Credit card number:_____Exp date:_____

☐ VISA ☐ MASTERCARD ☐ DISCOVER WE DO NOT ACCEPT AMERICAN EXPRESS

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