Surgical Patient Name:_____ Acct#:_____

Surgery Consultation Date:_____ Surgery Date: _____

Arrangements to provide credit card information for payment of deductible, co-insurance, and/or co-payments must be made with our office no later than one week prior to the scheduled date of surgery. This payment will cover your surgeon's services, and does not include any fees associated with the surgical facility, anesthesia, or pathology. You may contact the surgical facility in regards to their charges and payment requirements. Deductible, co-insurance, and/or co-payments that you are responsible for will be charged to your credit card upon receipt of benefits from your insurance company,

Please be advised that your surgery will be cancelled if arrangements for payment have not been made in advance of surgery date.

I authorize **Commonwealth Urology** to charge my credit card for any and all deductibles, co-insurance, and/or co-payments with regard to surgery consultation, surgery, and follow up visit for ((Patient's Name) _____on the date of _____.
If the surgery needs to be moved, verbal authorization to revise the date of this form will be given.

I authorize **Commonwealth Urology** to charge my credit card a rescheduling/late cancellation fee of **$350** for a procedure cancelled within **5 business days** of the scheduled time for anything other than a medical emergency or medical clearance issue.

Please Sign Here: _____

Credit Card: MasterCard Visa

Card Number: _____

Expiration Date: _____ **CVV Code (3 digits on back of card):** _____

Card Holder's Name: _____

Card Holder's Signature: _____