SHOLTES & ASSOCIATES, LTD., CREDIT CARD AUTHORIZATION

I, _____. hereby authorize Sholtes and Associates, LTD., to charge my credit/debit card for any account balance that is more than 60 days past due. I understand my card will be charged on a regular basis for these amounts.

I authorize my card to be charged for fees as indicated above.

_____ **PATIENT INITIALS**

Credit Card Number: _____
Exp. Date: _____ **CVV Code:** _____

Billing Address for the Credit/Debit Card listed above:

_____

_____

_____

Patient Name:_____

Signature:_____**Date:**_____

AUTOMATIC BILLING

Additionally, for your conveniece, if you wish to have your balance changed to your credit/debit card for any patient responsibility from services rendered (deductible, co-paymente, and co-insurances) and.or fees incurred (cancellations within 24 hours or no-show appointment) after each visit, please check auto-charge and initial below

_____ **Auto-charge**

_____ **Initials**

STATEMENT INFORMATION

You will receive statements from Sholtes and Associates, LTD., electronically, or US Mail.

Signature:_____ **Date:**_____