CENTER FOR
ADVANCED REPRODUCTIVE MEDICINE
& FERTILITY

Credit Card Authorization Form

In accordance with our **Office Financial Policy** and **Office Policy on Insurance Coverage**, a credit card authorization form is required to be on file to settle patient balances on the day they occur. Therefore, please complete the information below.

Patient Name:_____

Name Imprinted on Credit Card:_____

Billing Address of Credit Card:
Street # and Street Name:_____

City:_____ State:_____

Zip Code:_____

_____VISA _____Mastercard _____Discover ____American Express

(Note: Advanced authorizations are not accepted for Debit Cards.)

Credit Card #:_____

3 or 4 Digit Security Code (on back of card)_____

Credit Card Expiration Date:_____/_____
Month Year

I hereby authorize **The Center for Advanced Reproductive Medicine and Fertility** to charge the above credit card for any patient balance due. I understand that I will be telephoned should the amount to be charged exceed $500.00, or should the date of service to which the charge is related be greater than 1 year prior. I confirm that the above is a Credit Card and is not a Debit Card. This authorization will remain valid for 1 year from the date of the signature.

Signature:_____Date:_____

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