Naugatuck Valley
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PHYSICIAN: _____ **Card On File:** ☐ **DATE OF PROCEDURE**: _____

Credit Card Authorization Form

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____DOB_____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

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EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # _____

EXPIRATION DATE: _____/_____ VERIFICATION CODE (3 or 4 DIGITS) _____

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I acknowledge and authorize Naugatuck Valley Gastroenterology Consultants, LLC to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be charged after receipt of my insurance company's explanation of benefits (EOB) and there may be two separate charges on two separate dates. One charge will be for the physician fee and the second charge will be for the anesthesia fee.

I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date