SENIOR HEALTH ASSOCIATES Fax Completed Forms to 803.764.2361

CREDIT CARD PAYMENT AUTHORIZATION

☐ AMEX ☐MASTERCARD ☐VISA ☐DISCOVER

CARD NUMBER

EXPIRATION DATE (MM/YY)

CVC CODE (3 NUMBERS FROM BACK OF CARD)

PATIENT NAME DATE OF BIRTH

CARDHOLDER NAME

CARDHOLDER ADDRESS

CITY, STATE, ZIP

CARDHOLDER EMAIL

CARDHOLDER CELLPHONE

SENIOR HEALTH ASSOCIATES IS REQUESTING THAT PATIENTS VOLUNTARILY PROVIDE A VALID CREDIT CARD FOR PATIENT RESPONSIBLE CHARGES. AT THIS TIME, WE DO NOT REQUIRE THAT YOU DO SO UNLESS YOU ARE APPLYING AS A SELF-PAY PATIENT.

SHOULD YOU CHOSE TO PROVIDE US WITH A CREDIT CARD, WE WILL PROVIDE YOU WITH A SAME DAY RECEIPT FOR ALL CHARGES TO YOUR CARD. WILL APPLY CHARGES TO YOUR CARD ONLY AFTER YOUR INSURANCE CARRIER ADVISES OF THE REMAINING BALANCE IN PATIENT RESPONSIBILITY.

PROVIDING THIS INFORMATION WILL REDUCE LATE FEES THAT MAY OCCUR FROM LATE PAYMENTS TO YOUR ACCOUNT.

CARDHOLDER SIGNATURE