3500 Discovery Rd Suite 208 Westlake, PA 15090 PHONE (724) 799-8556 FAX: (412) 430-9303

Charge Authorization Form

Name (as it appears on Credit Card)

_____

Patients Name _____

Zip Code for Card Holder_____

Credit Card Number _____

Expiration Date _____

Three Digit Security Code on back of card _____

Is this card an FSA or HSA? Yes_____ No_____

If yes an alternate credit card is required

Alternate Card to FSA/HSA account

Name (as it appears on Credit Card)

_____

Patients Name _____

Zip Code for Card Holder_____

Credit Card Number _____

Expiration Date _____

Three Digit Security Code on back of card _____

Authorization Agreement

I agree to allow CAP Solutions to keep a valid credit card on file. This card information may be stored to pay future financial obligations. I understand that all financial responsibilities will be charged to this card with-in 5 days of the visit. If I change the credit card specified, I agree to provide written authorization for the new credit card to CAP Solutions immediately.

Card Holder Signature _____

Date _____