SILVER CROSS
MEDICAL GROUP
The way you *should* be treated.

AUTHORIZATION FORM

Silver Cross Medical Group
Authorization for Credit Card

NOTE: When your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Our system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

AUTHORIZATION
Until further notice, I authorize Silver Cross Medical Group to charge the patient responsibility balance on my account to the following credit card:

CIRCLE ONE: Visa MasterCard Discover AMEX
Last Four Digits of Credit Card Number: _____
Exp. Date (mm/yy): _____/_____

I understand that once the health plan has paid their portion for my care I will receive an Explanation of Benefits (EOB). The health plan EOB will state any remaining balance to be paid by me. I agree that Silver Cross Medical Group may charge my credit card the balance due upon receipt of the EOB. I also understand that Silver Cross Medical Group may charge my credit card any open balance due as well, if they determine that a prior balance exists.

Signature: _____ **Date:** _____
Printed Name: _____
E-Mail: _____
Patient Name (if different than above): _____
Patient Date of Birth: ____ / ____ / _____

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In all cases, proper communication should include “Any known payment responsibility is due at your visit. Any remaining balance as determined by your health plan is your responsibility. We require you to save a credit card for remaining balances.