Credit Card Authorization Form

Lori McAuliffe MD, PA

It is our policy to require all practice families to keep a credit card on file with us. Your payment is your contract with your insurance company and with us.

To ensure you only pay the amounts required by your insurance plan, we will be happy to charge your credit card when the exact amount is provided by your insurance company. This is also used for any applicable fees you have incurred.

Your credit card information will be kept confidential and secure as required by the PCI Securities Standards Council. Charges to your credit card will only be made after the insurance company pays its portion. Please apply this information to the following patients:

Patient Name (Print): _____ DOB: _____
Siblings: _____ DOB: _____
_____ DOB: _____

I authorize Lori McAuliffe, M.D., P.A. to charge the portion of my/my child's bill that is my responsibility to the following credit card:

Credit Card Type: □HSA Account □ VISA □ MasterCard □ AMEX □ Discover
Credit Card Number: _____ Exp. Date: _____
Cardholder Name: _____ Security Code: _____
Parent Signature: _____ Date: _____

Cardholder Signature: _____ (if different from Parent)
Billing Address: _____
_____
_____

Please let us know whether you require the following:
□ Call prior to charging my credit card:
Phone number: _____
□ Provide a receipt anytime charges are applied and E-mail to:
E-mail address: _____
Accepted by: ____ CZ ____ ET ____ PN _____ LI ____ AC ____ MM ____ CP ____ TM ____ LD