TRANSCEND MEDICAL

Going Beyond The Limits

800-403-3740

PAYMENT AUTHORIZATION FORM

Please provide the following in order for us to contact you with important information about your account.

Responsible Party Information

Patient Name: _____ DOB: _____

Responsible Party Name: (If different than patient) _____

Street Address: (billing address) _____

City _____ state _____ Zip _____ Home # _____

Email _____ Cell # _____

Do You prefer calls _____ Do You Prefer text _____ Do you prefer email _____

Payment Authorization for Automatic Payment

Our financial policy requires patients to have a form of payment on file to satisfy any patient responsibility. If you have provided insurance coverage to us, we will bill your insurance company with the necessary information. The balance remaining after insurance has applied is your responsibility, including insurance deductible amounts. Our office will send an invoice to you once your patient balance is determined. The credit card or bank account listed below will be automatically charged on the due date specified on your next invoice.

Provide either Credit Card or eCheck information:

	CREDIT CARD		eCHECK
Credit Card number		Your bank account number	
Expiration date		Bank Routing Number	
CVV code (3 digit on back)		Bank Name	
Name on Card		Name on Check	
Street address		Street address	
City		City	
State		State	
Zip		Zip	

I authorize TRANSCEND MEDICAL, to execute transactions on the above account. I consent to the use of the above payment method without my signature on the individual transactions in satisfying my obligations to TRANSCEND MEDICAL. I understand that a photocopy or fax of this agreement will serve as an original, and this payment authorization cannot be revoked unless done so in a 30 day written notice to the Provider.

Signature: _____ Date: _____