TRANSCEND MEDICAL

Going Beyond The Limits

800-403-3740

PAYMENT AUTHOIZATION 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 Address: ____ Cell # __________________________________

Do You Prefer calls _____ Do Your Prefer Text ______ Do You Prefer E-mail _______

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 been 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.

I Authorize the amount I owe to be taken out ____ Specific Amount _____ of ___________ One Time ______ Auto Pay ______

I prefer this to be withdrawn on this date if possible ______________

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 digits on back)		Bank name	
Name on card		Name on check	
Address Information for Card (if different than above)		Address Information on Check (if different than above)	
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: ___________________