Advanced Health Care

5333 Mission Center Road, Suite 100
San Diego, CA 92108
(619) 281-6414

Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last Name First Name Middle Initial

Name on Card (if different than above)_____

I authorize Steven Hirsch, Ph.D. and/or Advanced Health Care to charge my credit/debit card for professional services as follows:
Initial

_____ charges for date(s) of service, not to exceed $_____for the initial visit and $_____ for follow-up visits and for missed or late cancellations as indicated in our payment policies. *(Fill in this portion if you are paying out of pocket)*

_____ to charge my card for the balance of fees not paid by my insurance company within 120 days, or for missed or late cancellations as indicated in our payment policies. *(Fill in this portion if you are paying with insurance)*

Type of Card _____ VISA ____ MasterCard ____Discover _____AMEX

Expiration Date _____/_____

Card Number _____-_____-_____-_____

DVV Number _____ (3 digit number from back of card)

Card Holder's Billing Address for Monthly Charge Statements

_____

Street *City* *State* *Zip*

Card Holder Signature _____ Date _____/_____/_____