

Credit Card Authorization

By my signature below, I, _____, authorize Precision Aspiration and Biopsy and its Billing
Patient Full Name
Agents, to make charges to my credit or debit card for any remaining balance not billable/payable by my insurance carrier for services provided. I will be notified in advance of these charges occurring, and may receive a copy of the receipt at my request.

Name as it appears on card: _____
First name MI Last Name

Type of Card (circle): MasterCard VISA

Card #: _____ CVV: _____

Expiration Date: ____ / ____ / 20____

Zip code where billing statements for this card are sent: _____

I authorize Precision Aspiration and Biopsy to securely store this credit/debit card information and charge it as listed above.

Signature: _____

Date: ____ / ____ / 20____

In addition to me, this card may be used for the following people:

