HARSHAD PATEL, MD, PC

4994 LOWER ROSWELL RD, SUITE 29, MARIETTA GA 30068

PHONE: 770-977-2987, FAX: 678-236-6041

Credit Card Authorization Form

Please complete this form to keep your credit card on file as a guarantee that you will be present for all appointments scheduled. Your card will be charged if you fail to cancel an appointment within **48 hours** of weekdays notice or simply do not show up for your appointment. In that case, your card will be charged **$350** if it is a new patient appointment or **$140** if you are an established patient. Note: Flexible Spending Account Cards or Benny Cards **can't** be used due to the fact insurance companies will not pay for missed appointments.

I understand that I am financially responsible for all the charges, (including co-pays, co-insurance, unpaid insurance claims, no show or late cancellation, preparation of medical report, returned check charges etc,) and authorizes Harshad Patel MD PC to charge automatically to my credit card in file.

The undersigned agrees and authorizes HARSHAD PATEL, MD, PC to charge the credit card below:

Cardholder Name: _____

Cards Accepted: – Visa/ Master Card/Discover/ American Express (Please Circle One)

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ Security Code*: __ __ __ __

(*Security Code - 3 digit on the back of your card, except AMX – 4 digits on the front of card)

Credit Card Billing Address: _____

City: _____ State: _____ Zip: _____

Authorized Signature: _____