

Choices Counseling & Resource Center, P.A.

Preauthorization for Health Care

I authorize, Choices Counseling & Resource Center, P.A. to keep my signature on file and to charge my (circle one): Visa or MasterCard account for:

All balances not paid by insurance or other third-party payers after 60 days. This total amount cannot exceed \$ _____ .

Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: _____

Cardholder's name: _____

Cardholder's billing address: _____

City: _____ State: _____ Zip: _____

Charge card number: _____ Expiration date: _____

Cardholder's signature: _____ Date: ____/____/____