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# VISA / MASTERCARD / DISCOVER / AMERICAN EXPRESS Authorization Form

I authorize Alliance Clinical Associates, S.C. to process payments on my credit card for my sessions at Alliance (for co-pays, co-insurance, deductible, and for no show charges).

**Credit Card** *circle one (Visa, MasterCard, American Express, Discover), HSA, Flex*  
*Any payment over 500.00 will not be taken without card holder authorization*

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Patient Name(s)

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## Address

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Cardholder Name(s)

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City/State/Zip

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**Card Number 1**  
Circle one if Flex or HSA

Month / Year:    3-digit:  
Exp. Date    Code on back

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**Card Number 2**  
Circle one if Flex or HSA

Month / Year:    3-digit:  
Exp. Date    Code on back

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**Signature**

Today's Date

**Alliance prefers that all patients have a credit card on file. This conveniently assists in collection at the time of service and minimizes the need for other billing.**

**Account numbers are kept secure. At any given visit you may choose to pay by cash, check or defer to the credit card on file.**

Your cooperation is much appreciated