ALLIANCE CLINICAL
ASSOCIATES

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VISA / MASTERCARD / DISCOVER / AMERICAN EXPRESS
Authorization From

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

Patient Name(s) _____

Address _____

Cardholder Name(s) _____

City/State/Zip _____

Card Number 1 _____
Circle one if Flex or HSA

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

Card Number 2 _____
Circle one if Flex or HSA

Month / Year: _____ 4-digit: _____
Exp. Date Code on back

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