CREDIT CARD ON FILE

If you are a **NEW** patient, by signing this document you hereby authorize Equipped for Life to process your credit card payment on a monthly basis or as needed. This will include, but is **not limited to**; co-pays, deductibles, and any past due balances unpaid by your insurance company.

If you are an **EXISTING** patient, by signing this document you hereby authorize Equipped for Life to process your credit card payment for any and all payments due. This will include, but is **not limited to**; co-pays, deductibles, and past due balances unpaid by your insurance company.

_____ _____

Customer Signature Date

Patient Name: _____

Card Holder Name if different from patient: _____

Date of service: _____

Patient Account number: _____ (Caretinuum #)

Equipment or Supplies: _____

CREDIT CARD PAYMENTS – EQUIPPED FOR LIFE

Card Holder Name: _____

Credit Card Account Number: _____

Credit Card: _____Visa _____ Master Card _____ Discover _____AM/EX

Amount: $ _____ Expiration Date: _____ Security Code: _____

Mail Receipt: _____ Yes _____ No

Patient's Address: _____

City: _____

State: _____ Zip Code: _____

Representative completing this form: _____

THIS FORM WILL BE SHREDDED ONCE THE INFORMATION HAS BEEN ENTERED INTO OUR SECURE CREDIT CARD SYSTEM