Arthritis, Rheumatic & Back Disease Associates, P.A.
Greentree Osteoporosis Center

Fellows in the American College of Rheumatology

CREDIT CARD PRE-AUTHORIZATION

I authorize Arthritis, Rheumatic & Back Disease Associates, P.A. to keep my signature on file and to charge the credit card selected below for the following:

☐ **Balance remaining after claims(s) is (are) resolved not to exceed $_____for:**

- ☐ This consultation only
- ☐ All consultations this calendar year
- ☐ All consultations from Start Date: _____ to End Date: _____

☐ **Recurring charges of $_____ to be charged every _____ days / weeks / months**

- ☐ From Start Date: _____ to End Date: _____

☐ **Charges for the following family members:**

_____ (authorized family member)

_____ (authorized family member)

_____ (authorized family member)

_____ (authorized family member)

Check one: ☐ Visa® ☐ Mastercard® ☐ American Express® ☐ Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ **Date:** _____