



Commonwealth Surgical Associates

91 Montvale Avenue, Suite 208
 Stoneham, Massachusetts 02180
 Phone: (781) 279-1123

CREDIT CARD "on file" AUTHORIZATION FORM

I hereby authorize Commonwealth Surgical Associates, P.C. to maintain credit card payment information in their confidential files. The signature or signatures below authorize the credit card information to be reviewed and fees to be charged against the credit card below for fees not covered by insurance, deductible and co-pay portions of my medical and surgical services provided by Commonwealth Surgical Associates.

Patient's Name:	
Patient's Signature:	
Additional Authorized Credit Card user's Name:	
Additional Authorized Credit Card user's Signature:	
Witness Name:	
Witness Signature:	
Signature Date:	
This authorization will expire one year from the signature date.	

My signature below authorizes Commonwealth Surgical Associates, P.C. to charge my Credit Card for deductible and co-pay amounts as described above.

SELECT (✓) ONE CREDIT CARD TYPE			<input type="checkbox"/> Discover	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express
SELECT (✓) RECURRING CHARGES	CREDIT CARD NUMBER				EXPIRATION DATE (MM-YYYY)	
<input type="checkbox"/>	<input type="text"/>				<input type="text"/>	
<input type="checkbox"/> <i>Recurring charges</i>	AMOUNT OF PAYMENT FROM YOUR CREDIT CARD \$				<input type="text"/>	
PRINT NAME BELOW AS IT APPEARS ON YOUR CREDIT CARD						
ENTER THE UNIQUE THREE-DIGIT NUMBER FROM THE BACK OF YOUR CARD. <input type="text"/>						
SIGNATURE:					DATE:	

