7045 N Maple Ave Suite 101
Fresno, CA 93720
tel: (559) 900-4013
fax: (559) 900-4172

CREDIT CARD PREAUTHORIZATION FORM

I authorize Mittal Gastroenterology & Rheumatology to keep my signature on file and to charge fees, or partial fees, to my Credit Card account for services provided to:
_____according to the method I will specify below:
(Print Patient Name or Client Name)

[ ] Balance of charges not paid by insurance for each appointment including fees previously agreed upon.

[ ] For an existing balance, for which I will be charged $_____ every _____ days until total balance is paid.

I agree that:
If insurance/employee health benefits are assigned to Mittal Gastroenterology & Rheumatology, I am responsible for the total charges incurred regardless of any insurance denial or insurance partial payments unless other arrangements regarding fees have been made. This responsibility will be limited by any participating provider arrangements the physicians of Mittal Gastroenterology & Rheumatology may have with an insurance company or network.

This authorization is valid until cancelled in writing.

Charges for ongoing services will be posted to my credit card account within a week of each service date. Payments toward existing account balances will appear on my statement at agreed upon intervals. All charges will appear on my statement as "Mittal Gastroenterology & Rheumatology". The amount charged to my account will depend on use of services, insurance arrangements, and agreement now in effect with Mittal Gastroenterology & Rheumatology.

If I have any problems or questions regarding my charges to my account, I will contact the Billing Office at Mittal Gastroenterology & Rheumatology at (559) 900-4013. ***I agree that I will not dispute any charges with my credit card company unless I have first attempted to rectify the situation directly with Mittal Gastroenterology & Rheumatology.***

Cardholder Name (please print): _____

Billing Address (where statements are mailed): _____

City: _____ State: _____ Zip: _____

Card Type (circle one): Visa MasterCard AmericanExpress

Account Number: _____Exp: _____CCID: _____
(The CCID is a 3 or 4 digit number on the back of your card by your signature, usually after the account number)

Cardholder Signature:_____Date:_____