Patient ID #: _____

Credit Card Authorization Form

I,_____ , authorize Pain Specialists of Greater Chicago to capture my credit card information and to charge my credit card as payment for any balance put into the "patient responsibility" as a result of **patient (patients name)**_____ insurance plan's deductible, co-insurance , co-payment or for any self-pay fees due to office visits and urinalysis testing.

Name on Credit Card: _____

Cardholders Billing Address: _____

Cardholders ID or DL#: _____

OR

Last four digits of SS#: _____

I, _____ **(card holder)** will notify Pain Specialists of Greater Chicago Billing Department 630-371-9980(option 6/option1) when I no longer want my credit card/ debit card charged for **patient (patients name)** _____

Card Holder Signature: _____

Printed Name: _____ **Date:** _____

E-mail Address (please provide if you would like an e-mailed receipt):

_____

Patient Name: _____ **Patient DOB:** _____

PAIN SPECIALISTS OF GREATER CHICAGO
7055 HIGH GROVE BLVD• SUITE 100 • BURR RIDGE, IL 60527
Phone: 630-371-9980 option 6•• Fax: 630-371-1555