## Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN
All information will remain confidential

**Non-Membership Credit Card on File**

Patient Name: ______________________________________________

Patient Email: ______________________________________________

Name on Card: ______________________________________________

Billing Address: ______________________________________________

______________________________________________

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____________________________________________ Exp Date: _________

Card Identification Number: ______ (last 3 digits located on the back of the credit card)

I authorize Summit Health Group to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

I acknowledge that by waiving my membership benefits, Summit Health Group will charge my credit card for any Form Fees (ie. Sports Physical, Employer Forms, Disability Forms, etc.) and if applicable, any Medical Management Phone Consultation Fees (i.e. discussion of abnormal lab results, questions or changes to medications, adverse reactions, follow up questions, etc.).

**Complexity Level**
LOW
- Short Form requiring Doctor signature only or brief call with low complexity Medical Mgmt $50

MEDIUM
- Long Form requiring review and medical information entry or call requiring moderate complexity Medical Mgmt $75

HIGH
- Phone Consultation requiring high complexity Medical Mgmt $150

Signature: __________________________________________ Date: _____________

Printed Name: __________________________________________