ILLINOIS
Foot & Ankle
CENTER SC
Kelly N. May, DPM, FACFAS

CREDIT CARD AUTHORIZATION FORM

Illinois Foot & Ankle Center S.C. requires all patients to keep a credit card on file to cover any patient responsibility for services rendered.

Note: When your credit card information is entered it is encrypted and cannot be viewed or accessed by our organization. Our system is independently certified as PCI compliant, ensuring that strict security standards are in place.

AUTHORIZATION

I authorize Illinois Foot & Ankle Center S.C. to charge the patient responsibility balance on my account to the following credit card:

Circle One: Visa MasterCard Discover AMEX

Last Four Digits of Credit Card Number: _____

Expiration Date: (mm/yy) _____/_____

I understand that once the insurance has paid their portion, I will receive ONE statement from Illinois Foot & Ankle Center indicating my responsibility.

I agree that Illinois Foot & Ankle Center may charge my credit card the balance due if it is not paid in 30 days of the statement date. I also understand that Illinois Foot & Ankle center my charge my credit card any open balance due as well if they determine that a prior balance exists.

Printed Name: _____ Date: _____

Signature: _____

Patient Name (if different than cardholder): _____

Patient Date of Birth: _____/_____/_____