MID STATE MD, LLC
PERSONAL CHOICE SURGICAL CENTER, LLC

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Plastic, Reconstructive & Cosmetic Surgery
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CREDIT CARD AUTHORIZATION

I authorize Mid State MD, LLC and/or Personal Choice Surgical Center, LLC to keep my signature on file and charge my credit/debit card for charges not paid or balances not paid by my insurance. This includes all co-payments, deductibles, and out of pocket costs.

Your credit card will not be billed until your insurance company has paid or denied your claim and you have been sent at least 2 statements without making a payment. We will mail you a copy of the credit card receipt for your records.

I have read the above policy and agree to its terms.

_____/_____/_____
Card # Exp date Security code

_____
Patient Name (Please Print)

_____ _____
Patient Signature/Preauthorized Date
Credit Card Signature “on file” for Health Care Expenses