GASTROENTEROLOGY/HEPATOLOGY ASSOCIATES, LLC
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Re: **PRE - AUTHORIZATION PAYMENT OPTION**

Dear Patient: ________________________________.

In an effort to provide you with flexible payment arrangements, we have arranged a a pre authorized payment option. The purpose of which is to provide you with a hassle free way to pay the balance of your charges which are not paid by your insurance carrier(s), specifically any co insurance,co pays and surgical deductible due to diagnostic procedures which have been deemed by your carrier(s) to be your responsibility.

We will not process any amount over $300.00, unless you give us authorization.

I authorize the billing manager of Gastroenterology Hepatology Associates, LLC to bill my credit card up to $300.00 for any patient responsibility assigned by my insurance. This authorization is active for 90 days from the following date:______________________.

Gastroenterology Hepatology Associates, LLC is a fully approved and accredited user of Visa and Master Card Health Care Programs which will enable you to use your Visa/MC to automatically cover the amount not paid by the insurance. *This information will be scanned and confidentially stored in a secure document folder under your name. Our office follows and adheres to the HIPAA guidelnes.*

Patient Name:____.

Cardholder Name: [ ] Same as patient [ ] Other: ________________________________.

Account Number: ____________________________Expiration Date: _______________.

CVV Number: ___________.

_____________________________________. Date__________________________.
Cardholder Signature

_____________________________________. Date__________________________.
Office Representative