IVAN L. MAZZORANA, JR., M.D., P.A.

Credit/Debit Card on File Policy Payment Authorization Form
Our office requires your credit or debit card to be kept on file.

Recurring Payments Will Make Your Life Easier:
•It's convenient (saving you time and postage)
•Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged following each scheduled visit for the portion of services that your insurance doesn't cover. (i.e. copay, coinsurance amount, deductible, or Self pay fee). A receipt will be available upon request and is also included in your monthly credit card statement. You agree that no prior notification will be provided if the total payment is under $300.00. If your bill is more than that amount, we will contact you in advance prior to charging your credit card. There will be a $15.00 charge if your credit card declines when processed at the time of service. Please note there is a charge of $100.00 for missed appointments, when you fail to give 24-hour notice of cancellation.

Please complete the information below:

I authorize Ivan L. Mazzorana, Jr. M.D., P.A. to charge my credit
(full name)
Card for the amount that is not covered by my insurance company.
I understand that I will only receive advance notice of the charge if it exceeds $300.00
Billing Address _ Phone #
City, State, Zip _ Email _
Account Type: Visa MasterCard Amex Discover
Cardholder Name_
Account Number
Expiration Date
CVV _
SIGNATURE DATE

I authorize Ivan L. Mazzorana, Jr. M.D., P.A. to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a week-end or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this office in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next scheduled appointment. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.