

Shawnee Metabolic Management Center

21624 Midland Drive

Shawnee, KS 66218

(913) 643-0075 (913) 643-0077 FAX

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

This authorization is for the patient responsibility portion of your bill. For contracted insurance this will be the amount remaining after insurance payment and adjustment. We acknowledge that the origination of ACH transactions to your account must comply with the provisions of U.S. law.

Patient Name _____ Patient Date of Birth _____

Copy of form of payment – check/credit card

Credit Card # _____

Expiration Date __ / __ Security Code

Master Card Visa Discover American Express Care Credit (Circle One)

I authorize Shawnee Metabolic Management Center to keep my signature on file, and to charge the credit card identified above for the balance of charges not paid by my insurance company. This authorization is for all treatment for the patient above named, or as indicated below.

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- At any time, I may elect to pay my account in full to prevent this authorization from being activated.
 - I should receive an Explanation of Benefits from my insurance company within 45 days showing my balance.
 - I will be notified by billing statement before charges are sent to my credit card.
 - I may set up a payment plan for balances over \$500.

I assign my insurance benefits to Comprehensive Women's Care, Inc. DBA Shawnee Metabolic Management Center. I understand that this form is valid for one year unless I cancel the authorization through written notice to Comprehensive Women's Care, Inc. DBA Shawnee Metabolic Management Center.

Signature

Date