Credit Card/ Care Credit Remote Authorization

By signing below, you are authorizing a charge to your credit card/Carecredit account in the amount specified. To protect your credit, we need you to verify your identity and return the following information to us. This eSignature form is an encrypted, HIPAA compliant document that is returned directly to our accounting department. If this is a prepayment for a service, we will also have the patient sign and provide ID at the time of service.

1. Sign, date and return this letter
2. Include a copy of card holders picture identification (driver's license, state issued or Military ID)

Card Holder: _____

Care Credit Account Number: _____

Regarding Patient: _____

Account # _____

Date of Service: _____

Amount of Charge: _____

Please be aware that any refunds will be returned to the patient unless you call with the card number and request payment be refunded to your account.

I am authorizing payment of the above patient's charges remotely.

_____ _____
Card Holder Signature Date

_____
Printed name:

Thank you for your payment
Hollingshead Eye Center
PH: 208/336-8700
Fax: 208/426-0902

Processed by: _____