CITY CARE
FAMILY PRACTICE

160 East 32nd Street Suite #102
New York, NY 10016
Phone: (212)545-1888 Fax: (212)545-1919

Chart Number _____
(Office use only)

Attention:

1 We will notify you to let you know how much will be charged to this credit card two days in advance.

2 We **will not be responsible in any way what so ever for fees incured to you** because you do not have sufficient balance/spending limit on this credit card provided.

3 Any outstanding balances will be forwarded to a collection agency in **one month** from the date of the first invoice or call, even though you are on vacation or business trip.

4 If you want to appeal your insurance company's payment decision, please settle your account with us first. We will schedule a credit card reimbursement as soon as we receive the payment from your insurance co.

5 It is your responsibility to update your contact information.

* City Care Family Practice is responsible for the security of cardholders data.

Credit Card Authorization Form

I, _____(Please Print Name) authorize City Care Family Practice P.C. to charge medical fees to my Credit Card.

Name (Please print):		
Phone number: ( ) -	Alternative Phone number: ( ) -	
Billing address for this credit card		
City	State	Zip
Name as it appears on the credit card (if different than above):		
Card number: - - -	Expiration Date: /	
Select type of card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover		
CVV2 Number (last 3 or 4 digit number on the back/front of the credit card):		
Signature:	Date:	

Revised 02/14/2017