advanced direction

530 Rockland Road, Suite 100
Crystal Lake, IL 60014
815-345-3072

Credit Card Authorization

I authorize Advanced Direction to keep my signature on file and to charge my credit card account for:

___ All balances not paid by insurance or other third-party payers after 60 days. This total amount cannot exceed $ __________________.

___ Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: ____

Cardholder's name: ____

Cardholder's billing address: ____

City: _______________________ State: _____________ Zip: ___________

Charge card number: _______________________________ Expiration date: ___________________

Cardholder's signature: ______________________________________ Date: ______/______/______