CREDIT CARD ON FILE AGREEMENT

Your credit card on file will be used for all charges incurred for services at DeBalzo, Elgudin, Levine, Risen LLC. If covered by insurance payments to your credit card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account. Upon request, a receipt may be given or mailed to you after any charge has been made to your credit card.

Please complete the following if you would like us to provide this service to you:

I authorize DeBalzo, Elgudin, Levine, Risen LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

____Visa ____MasterCard ____AMX

Credit Card Number:

_____

Expiration Date: _____ / _____ / ____ 3 Digit Code: _____

Cardholders Name: _____

Address: _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request DeBalzo, Elgudin, Levine, Risen LLC to charge my credit card, indicated above, for all balances due for any services rendered including those that my insurance company identifies as my financial responsibility.

This authorization includes all fees not covered by my insurance company for services provided to me by DeBalzo, Elgudin, Levine, Risen LLC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel this service, written notification must be given to DeBalzo, Elgudin, Levine, Risen LLC.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____

CANCEL THE ABOVE AUTHORIZATION EFFECTIVE AS OF THIS DATE: _____/_____/_____

Patient Name (Print): _____

PATIENT SIGNATURE: _____DATE: _____