CENTER FOR SIGHT

1360 East Venice Avenue
Venice, FL 34285
Telephone: 941-488-2020 | Facsimile: 941-484-2200

ADVANCE CREDIT CARD PAYMENT AUTHORIZATION FORM

I, _____, authorize Center For Sight to charge
Printed name of account holder as indicated on credit card

my credit card in the amount of $ _____ on _____

for the scheduled surgery for:

Patient Name:	**Patient Medical Record #:**	
Physician:	**Date of Surgery:*** **Verify prior to processing payment*	
Card Type:	**Expiration Date**:	
Card #:		**Security Code:**
1st ID Type (Circle one): Driver's License State Issued Federal Government		
ID#:	**State:**	**Expiration Date:**
2nd ID Type:	**Expiration Date:**	
Account Holder Signature:	**Date of Authorization:**	

Patient will receive a copy of the receipt the day of surgery when he/she signs the transaction slip.

Credit Card Statement Mailing Address:

Full Street Address:		
City:	**State:**	**Zip:**

Security Attestation: By my signature below, I confirm that this personal patient / financial information will be scanned into a secure system drive to which no other individual has access and then promptly shredded. E-mail history will be similarly deleted. Upon the satisfactory completion of the authorized transaction, the financial information on this Authorization will be depersonalized, scanned into Center For Sight File Center and deleted from my secure system drive.

_____ _____

CFS Representative (Signature) **Date**