**Endocrine Specialists of Georgia, LLC**
1820 The Exchange SE Suite 100, Atlanta, GA 30339
770-515-9566 • FAX 800-604-3410
Francisco Puentes, MD, FACE

# Credit Card Payment Consent Form

PATIENT NAME _____ _____ _____
Last Name First Name Middle Initial

FULL NAME ON CARD: _____

CARD TYPE: Visa ☐ Master Card ☐ American Express ☐ Discover ☐

CARD NUMBER _____ EXPIRATION:_____/20 _____
CVV: _____

CARDHOLDER BILLING ADDRESS: _____
(Street)

_____
(City) (State) (Zip Code)

I _____ (print name) hereby authorize Endocrine Specialists of Georgia, LLC to charge my card for missed or last minute canceled follow up appointments (cancellations are to be done at least 48 hours before appointments and fee is at this time **$50**) . I also agree to be charged for any unpaid balance due to medical services or forms prepared by my request
(forms preparation have a cost between **$50-100**). If I have questions about these charges, I agree to contact Endocrine Specialists of Georgia, LLC via phone. I agree that I will not pursue a refund directly through my credit/debit card company, bank or financial institution. If any of my actions yield a charge back for any reason, I agree to pay all penalty fee (s) incurred by my provider.

My signature below indicates that I have read, understand and that I am in agreement with the Credit Card Payment Consent Form:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____