Retriever
Medical/Dental Payments

MasterCard VISA

Pre-Authorized Healthcare Form

I authorize _____
(name of healthcare provider)
to keep my signature on file *and* to charge my MasterCard® or Visa account as indicated below:

Check One: ☐ MasterCard ☐ Visa ☐ Other

☐ Balance of charges not paid by insurance within 90 days and not to exceed $ _____ for (indicate one):

☐ this visit only.

☐ all visits this year.

☐ Recurring charges (on-going treatments) of $_____

every _____ (frequency) from _____ (date) to _____ (date) .

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 the healthcare provider.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

_____ Mo._____ Yr._____
Account Number Expiration Date

X _____
Cardholder Signature Date

Provider Copy - White **Patient Copy - Yellow**