

**AUTHORIZATION TO CHARGE  
SERVICES TO CREDIT  
CARD OR DEBIT CARD**

I authorize LaGrange Women’s Health to charge to my credit card/debit card under the following circumstances:

1. For co-payments, deductibles, non covered services, medically unnecessary services and co insurance balances. The balance will be applied to the credit card listed below.

OR

2. If my insurance is with a company with which our physicians ARE NOT contracted, I understand that I am responsible for the entire amount at the time of service and that these charges will be automatically applied to the credit card listed below.

File out this form and we will keep it on file. This information will be kept strictly confidential.

Name as it appears on credit card \_\_\_\_\_  
VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ American Express \_\_\_\_\_  
Credit card #: \_\_\_\_\_ EXP \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Contact number \_\_\_\_\_ LWH ACCT# \_\_\_\_\_

Brandi Knox, our office manager, will contact you with the amount that will be charged to your credit card. If you have a HRA with your insurance company please let us know.