WEIL FOOT & ANKLE INSTITUTE

AUTHORIZATION AGREEMENT FOR PAYMENT OF YOUR BILL

This authorization is for the patient responsibility portion of your bill. For contracted insurance, this will be the amount remaining after insurance payment and adjustment by your insurance company.
We acknowledge that the origination of transactions to your account must comply with the provisions of U.S. law.

Patient Name_____**Pt. Acct #**_____
(Please Print)

Cardholder's Name _____
(If different from patient)

Credit Card #_____
LAST 4 DIGITS IN CODE

Expiration Date_____ **Security Code**_____
Mo/Yr **DIGITS IN CODE**

(Circle one) Master Card Visa American Express Discover CareCredit

I authorize Weil Foot & Ankle Institute to keep my signature on file and to charge the credit card identified above for the balance of charges not paid by my insurance company 60 days or more following date of service. This is for all treatment provided for the above named patient.

Patients that are scheduled to see Dr Lowell Weil Sr., Dr Lowell Weil Jr., or Dr David O'Brian must leave a credit card on file or leave a cash payment of $150.00 prior to seeing the doctor.

***No credit card charge will be made until 60 days or more following date of service.**

I will be notified by billing staff or statement of any charges made to my credit card.

At any time, I may elect to pay my account in full to prevent this authorization from being activated.

I assign my insurance benefits to Weil Foot & Ankle Institute. I understand that this form is valid unless I cancel the authorization through written notice to Weil Foot & Ankle Institute.

CARDHOLDER SIGNATURE (If different from patient) DATE

PATIENT SIGNATURE (parent signature if under 18) DATE

WEIL FOOT &ANKLE INSTITUTE 1455 GOLF RD DES PLAINES, IL 60016