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GLACIER EAR NOSE THROAT

Kay Lynn Benko, M.S CCC-A.
Hannah M. Sims, Au.D. CCC-A
Courtney Kasin Mann, Au.D. CCC-A
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Otolaryngology ● Head and Neck Cancer Surgery ● Nasal & Sinus Surgery ● Allergy
Thyroid & Parathyroid Surgery ● Audiology ● Facial Plastic and Reconstructive Surgery

Credit Card Authorization Form

PLEASE PRINT LEGIBLY AND RETURN TO GLACIER EAR NOSE AND THROAT
All information will remain confidential.

Patient Name: _____ Patient Account Number: _____

I, _____, authorize Glacier Ear, Nose & Throat to charge the agreed amount listed below, on the agreed dates, to the credit card herein listed. This agreement is for payment for the current balance of _____.

I understand that statements will be withheld for these services until the balance is paid in full. To satisfy the balance completely I authorize Glacier Ear, Nose & Throat to charge the remaining balance if less than the agreed regular payment.

Cardholder Name: _____
Billing Address: _____
_____
_____
Credit Card Type: ____☐____ Visa ____☐____Mastercard
Credit Card Number: _____
Expiration: ____/____ CCV: _____ (3 digit number on back of card)
Amount of Charge: $_____
Weekly ____☐____ Monthly ____☐____ Day of Debit: _____

Cardholder Signature: _____ Date Signed: _____

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