JOHN C. CHIU, M.D.
FAMILY PRACTICE

100 LOS GATOS SARATOGA ROAD, SUITE B
LOS GATOS, CALIFORNIA 95032

OFFICE (408) 863-0709
FAX (408) 863-0245

PREAUTHORIZATION OF PAYMENT

Though you have insurance, your insurance company will not guarantee our office payment for your visit. Due to this uncertainty, our clinic requires you to sign this credit card statement. This authorization will be used only if your insurance company declines payment for your visit. If you do not wish to sign this credit card statement you may instead pay for the total cost of the visit today. We will still send your claim to your insurance company and if your insurance company does pay for the visit, you will be reimbursed for your payment. Please realize that it may take as long as 2 months for your insurance company to process your claim.

I authorize John C. Chiu, M.D. to keep my signature on file and to charge my credit card account for:

☒ Balance of charges not paid by insurance within 90 days and not to exceed $320.00 for:

- ☐ this visit only
- ☐ all visits this year
- ☐ all visits from_____(date) to_____(date)

☐ Recurring charges (ongoing treatments) of $_____

every_____(frequency) from_____(date) to_____(date)

I assign my insurance benefits to the provider listed above. I understand this form is valid for eighteen months unless I cancel the authorization through written notice to the health care provider.

Patient Name:_____

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name:_____

Cardholder Address:_____

City:_____State:_____Zip:_____

Account Number:_____Expiration Date:_____

Cardholder Signature:_____Date:_____