

CENTRAL FLORIDA PULMONARY GROUP, P.A.

PAYMENT AUTHORIZATION

For Office Use Only	
Date: _____	Account: _____
Cycle: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	

Patient Name _____	Birth Date _____	Today's Date _____
Street Address _____	City _____	State _____ Zip _____

Reason for Payment Due

Your insurance carrier has has not paid on your account and the balance below reflects your responsibility:

Reason	Amount	Service Date
<input type="checkbox"/> Copayment		
<input type="checkbox"/> Deductible		
<input type="checkbox"/> Other Primary Insurance Coverage		
<input type="checkbox"/> Coverage Terminated		
<input type="checkbox"/> Coinsurance		

Reason	Amount	Service Date
<input type="checkbox"/> Non-Covered Service		
<input type="checkbox"/> Non-Authorized Service		
<input type="checkbox"/> Additional Information Requested by Insurance		
<input type="checkbox"/> Service/Procedure Not Covered		
<input type="checkbox"/> Other:		

Payment Options (please check one):

Option One:

Check Money Order Cash

Please mail payment to:

Central Florida Pulmonary Group, P.A.
Attn: A/R Department
1109 East Ridgewood Street
Orlando, Florida 32803

Option Two:

Visa* Master Card*

***Visa/Master Card Authorization**

Amount Charged: \$ _____ Expiration Date: _____

Card Number: _____ Authorization Date: _____

Name on Card: _____

I hereby authorize a one (1) time automatic charge against my credit card by Central Florida Pulmonary Group, P.A. as described above.

Cardholder's Signature: _____ (Required)

You may either:

Fax this authorization to
407-649-8677
Attn: A/R Department

OR

Mail authorization to:
Central Florida Pulmonary Group, P.A.
Attn: A/R Department
1109 East Ridgewood Street
Orlando, Florida 32803