CENTRAL FLORIDA PULMONARY GROUP, P.A.
PAYMENT AUTHORIZATION

For Office Use Only

Date: _________ Account: ___________

Cycle: ☐1 ☐2 ☐3 ☐4 ☐:

_______________ ____________________________ ______________________ ______________________

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
☐ Copayment		
☐ Deductible		
☐ Other Primary Insurance Coverage		
☐ Coverage Terminated		
☐ Coinsurance		

Reason	Amount	Service Date
☐ Non-Covered Service		
☐ Non-Authorized Service		
☐ Additional Information Requested by Insurance		
☐ Service/Procedure Not Covered		
☐ 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