UROLOGY ASSOCIATES OF DANBURY, P.C.

ADULT & PEDIATRIC UROLOGY

www.danburyurology.com

AUTOMATIC BILLING AUTHORIZATION FORM

You will receive a statement upon receipt of your explanation of benefits (EOB) from your insurance company. If payment is not made within 30 days of the statement date, UAD will process the balance on the provided credit card.

Note: Your credit card information is NOT kept on file in this office. It is kept by our PCI compliant credit card processor and this office does NOT have access to the full credit card number once it is entered.

Authorization:

I authorize Urology Associates of Danbury to charge my patient responsible balances on my account to the following credit card:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Last 4 digits of credit card: _____ _____ _____ _____

Expiration Date: _____/_____/_____

In the event that I have a balance more than 30 days past due, I authorize UAD to charge that balance to the card indicated above.

_____
Card Holder Name

_____
Card Holder Signature

_____ _____
Patient Name Date

FileName:automaticbillingauthorizationform

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