Pre-authorized Healthcare Form

I authorize Beaver Medical Group to keep my signature on file to charge my Visa, Mastercard, American Express, Discover or Other account as indicated below.

This card will only be used for any outstanding balance on my account after 90 days, Beaver Medical agrees to notify me if this card is going to be used.

☐ Visa

☐ Master Card

☐ American Express

☐ Discover

☐ Other

I assigned my insurance benefits to Beaver Medical Group. I understand that this release is good for one year unless I cancel this authorization through written notice to Beaver Medical Group.

Patient Name: _____

Cardholder Name _____

Cardholder Billing Address: _____

City: _____State: _____ Zip: _____

Account Number: _____Expiration Date: _____

Cardholder Signature: _____ Date: _____

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