



14 Manchester Square, Suite 250, Portsmouth, NH 03801

Phone: 603-431-6070

17 Riverside Street, Suite 205, Nashua, NH 03062

Phone: 603-882-8866

If you would like us to keep your credit card on file and authorize us to use it for balances please fill out the form below:

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. You will be given a courtesy call prior to any charges being processed.

I authorize Portsmouth Foot and Ankle DBA Northeast Foot & Ankle to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Select: Visa MasterCard Discover AMEX Care Credit

Credit Card Number _____

Expiration Date ____ / ____ **CVC** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, understand the above, and authorize and request **Portsmouth Foot and Ankle DBA Northeast Foot & Ankle** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by **Portsmouth Foot and Ankle DBA Northeast Foot & Ankle**. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to **Portsmouth Foot and Ankle DBA Northeast Foot & Ankle** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ **Date:** ____ / ____ / ____