FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD
659 West Washington Blvd, Chicago, IL 60661 312-707-8988
7845 South Cottage Grove Ave, Chicago, IL 60619 773-892-0102

Credit Card Authorization Form

FOR USE **ONLY** ON BALANCE DUE ACCOUNTS

Patient Information:

Patient Name: ____

Credit Card Holder's Name: ____
(As it appears on the card)

Credit Card Holder's Address: ____

____

Phone Number: (__________)__________-__________________

Payment Information:

Type of Credit Card: ______ Visa ______ MasterCard ______ Discover

16 Digit Card Number: ____

Expiration Date: (________/___________) 3 Digit Security Code: _________________ (From the back of card)

Payment Information

$____________.________ ______ One-Time Charge ______ Monthly ______Weekly

I authorize Family Planning Associates Medical Group, LTD (FPA) to charge my personal credit card listed for the amount authorized above for the balance due on my account. I agree to pay the amount which has been explained above. I understand that Family Planning Associates Medical Group, LTD will not process this payment until this original form is signed and a copy of my picture ID is received by our facility.

Signature: ____ Date: ____/_____/________

Please mail, fax or email this completed form to:

Family Planning Associates Medical Group
659 West Washington Blvd.
Chicago, IL 60661
Attn: Patient Accounts

Fax: (312) 707-9223

Or email to: krabbitt@fpachicago.com

_______ I request for Family Planning Associates Medical Group, LTD to mail my receipt(s) to my billing address when my balance is zero.