



Credit Card Authorization

NYU VEIN CENTER ♦ 530 First Avenue, Suite 6D ♦ New York NY 10016

Patient Name: _____

MRN: _____

It is our office policy to maintain a credit card on file for each patient. Should your account fall into arrears greater than 30 days or if there is a balance on the account after the insurance carrier has met its responsibility, I authorize that the unpaid balance be charged by NYU Vascular Surgery Associates to the credit card as listed:

MasterCard

Visa

American Express

Credit Card #: _____ - _____ - _____ - _____

Exp. Date: ____ - ____

Signature: _____ Date: _____