SAFEGUARD
RADIOLOGY INTERPRETATION

CREDIT CARD AUTHORIZATION FORM

*******AUTOPAY*******

Return via Fax (502) 427-7797 or email info@brookegajeski.com

Referring Physician/Cardholder Name: _____

Office Name: _____

Today's Date: _____

(Circle One) VISA/Mastercard -or- AmEx -or- Discover

Credit Card Account #: _____ Exp Date: _____ CCV#: ____

Card Billing Information (Please Print)

Name as it appears on card: _____

Cardholders billing address: _____

City: _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

I _____(name of card owner) authorize Safeguard Radiology Interpretation Services, LLC/Dr. Brooke L. Gajeski, DC, DACBR to charge the above credit card for:

- Second opinion diagnostic imaging interpretation requested by me or by the referring physician noted above.
- Primary or second opinion Personal Injury interpretation not paid by Med Pay or attorney as noted in the Safeguard Radiology Interpretation Services ***Billing Policies Document***.

Charge card: (choose one) Monthly _____ Biweekly _____ After each service_____

Upon expiration of the above credit card, I will provide Safeguard with a new credit card if I continue to elect the AUTOPAY option.

_____ _____

Signature of Cardholder ***Date Signed***