AITC IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Preauthorized Healthcare Payment Form

I understand that Adult Immunization & Travel Clinic, San Francisco Dept. of Public Health (AITC), will submit claim(s) to my healthcare insurance company for the charges incurred and I hereby authorize **AITC or its designee, ZirMed Inc. / Elavon Inc.,** to charge my Visa, MasterCard, Discover, or American Express as indicated below, for the entire remaining balance of the charges that are not paid to AITC by my healthcare insurance company. If the credit card on file is declined and a new credit card is obtained, I authorize the new credit card to be charged. This authorization includes balance charges for initial and follow-up visit(s) from:

Today's date _____ /_____ /_____ through 3 months from today or later date: ____ /____ /_____.

Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Last 4 digits of Card Number **XXXX-XXXX-XXXX-**☐☐☐☐**(required)**

Expiration date: ☐☐ ☐☐

Last 4 digits of Card Number **XXXX-XXXX-XXXX-**☐☐☐☐**(optional/ secondary)**

Expiration date: ☐☐ ☐☐

Patient Name ____

Cardholder Name (if different than Patient) ______________________________

Cardholder Billing Address ______________________________________

City, State, Zip ____

Please Present Your Credit Card to the Front Desk

____

Card Holder's Signature /Authorized User Signature ***Date***