ARIZONA ADVANCED SURGERY

Credit Card on File Refusal Form

Patient Name: _____ **DOB**: _____

By signing this form, I understand that by opting out of credit card on file I will be required to pre-pay for all services according to my benefit plan. I also understand that any remaining balances must be paid within 14 days of receiving the first statement or I will be charged a fee of $25 service fee for each additional statement generated.

_____ _____

Patient Signature Date Staff Signature Date