

M I D W E S T

EAR, NOSE & THROAT

"Discover a Healthy New You!"

2315 W. 57th Street, Sioux Falls SD 57108 | (605) 336-3503 | Fax (605) 336-6010 | 888-336-3503
www.midwestent.com

Credit Card Pre-Authorization Form

I authorize Midwest Ear, Nose & Throat to keep my signature on file and to charge the credit card selected below for payment on my account until paid.

Balance remaining after claim (s) is (are) resolved to be paid

\$ _____.

Recurring charges of \$ _____ to be charged

every month from the following dates:

from _____ to _____.
(month & day) (month & day)

Charges for the following family members:

_____ (authorized family member & account number)	_____ (authorized family member & account number)
_____ (authorized family member & account number)	_____ (authorized family member & account number)

Check One: Visa® Mastercard®
 Discover Card® American Express®

Cardholder Name: _____

Cardholder Address: _____

City: _____ **State:** _____ **Zip:** _____

E-mail address: _____

Credit Card Number: _____

Expiration Date : _____ **Authorization Code:** _____

Cardholder Signature: _____

Date: _____ **Midwest ENT Rep.** _____

BOARD CERTIFIED OTOLARYNGOLOGISTS

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