471 W. 36th Avenue Suite 110, Anchorage, AK. 99503
P: 907 903 - 7123 F: 855 952 - 3836 info@bordercounseling.com

Pre-Authorized Use of Credit Card

I authorize Border Counseling Services LLC

to keep my signature on file and to charge my Visa / MasterCard for:

☐ Balance of charges not covered by insurance or insurance deductibles payable within 90 days and not to

exceed $ _____ for: (maximum charge per transaction)

☐ Recurring charges (copayment or payment plan) of
$ _____

☐ for visits no matter the day.

☐ all visits this year.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

_____
Patient Name DOB

_____
Cardholder Name

_____
Cardholder Address

_____
City State Zip

_____
Credit Card Account Number Expiration Date Security Code

_____
Cardholder Signature Date