CREDIT CARD AUTHORIZATION

I, _____, hereby authorize William P. Adams, Jr., MD PA, anesthesia and surgical center to charge my account up to **$75.00** for services rendered in connection with my surgical consultation performed by William P. Adams, Jr., M.D. Any amount in excess of this will require additional authorization.

Signature:	
Name as it appears on the card:	
Credit Card Type:	
Account Number:	
Expiration Date:	
3 Digit Security Code	
Amount to be Charged:	$75.00

Cancellation Policy - We apologize in advance for any inconvenience this may cause but it is necessary for us to maintain our schedule.

To better serve our patients, our office requires a 72 hour notice to cancel an appointment. Failure to provide a 72 hour notice will result in a service charge of $75 for an appointment, which will *not* be covered by insurance. We understand that rare instances may occur when it would not be possible to give such notice; unless an emergency (documented) arises. We ask that one be respectful of our time and of other patients who are waiting to get an appointment by adhering to this cancellation policy.

_____ _____

Patient Signature Date

Please fax back to (214) 965-9180