PHYSICIANS GROUP
OF SOUTH FLORIDA, P.A.
Quality Personal Care

INTERNAL MEDICINE
JANE S. COHEN, M.D.
MARTIN DROST, M.D.
LEILANY IRIZARRY-COLON, M.D.
BRIAN G. PACHTER, D.O.
DANNY ABOUEKDE, D.O.
JONATHAN POMPER, M.D.

GASTROENTEROLOGY & ENDOSCOPY
DAVID COHEN, M.D.
ARIN H. NEWMAN, M.D.
DANIEL L. WOLFSON, M.D.

Authorization to Charge Credit Card Form

For Future GI Procedure

Patient Information

Patient's Name: _____ **Date of Birth**: _____

Procedure (s) Scheduled: _____

Procedure Date: _____

Insurance Plan: _____

Financial Responsibility

By signing this form, I acknowledge that I have been informed of my estimated deductible or coinsurance responsibility for the upcoming procedure. I understand that my insurance may not cover the full cost, and I am responsible for paying the remaining balance.

The estimated amount that I am responsible for is:

- **Deductible/Coinsurance Amount**: $_____
- **Method of Payment**: Credit Card

Authorization to Charge Credit Card

I authorize **Physicians Group of South Florida** to charge my credit card on file for any unpaid deductible, coinsurance, or other outstanding balances related to the procedure listed above. I understand that this charge will be processed the day prior to the procedure if payment has not been received. Charges may include any applicable deductible, coinsurance, or the full cost of the procedure if no insurance coverage is available.

Credit Card Number: _____**Expiration Date**: _____

CVV Code: _____ **Zip Code**: _____

_____ _____

Patient's Signature: **Date**:

Mt. Sinai Medical Center
4308 Alton Rd Suite 710
Miami Beach, Florida 33140
Tel: 305-674-5925 *Fax: 305-674-5927

Causeway Square
1801 NE 123rd Street Suite 405
North Miami, Florida 33181
Tel: 305-692-6100* Fax: 305-692-6101

WWW.PGSFL.NET