SOMNIQUE
SLEEP HEALTH

Patient Name: _____

Date: _____

CONTINGENCY CREDIT CARD AUTHORIZATION FORM

In the event my insurance carrier sends payment directly to me for services rendered by Somnique Health, and I do not forward that payment to Somnique Health within 15 days of the insurance check date, I authorize Somnique Health to charge any outstanding balances on my account to the following credit card:

_____ Visa
_____ Mastercard
_____ Discover
_____ Health Savings card

Account# : _____ Expiration Date: _____

Name on the Card: _____

The amount charged will be the outstanding balance, but will not exceed $3000.

I authorize a copy of this authorization form to be used in place of the original.

*Please note that your credit card information will be stored in a secure location and will ONLY be used in the above situation.

_____ _____
Signature Date