

**Dr Allen Kuo**  
Selah Healthcare Professionals  
1000 Hart Rd, Ste 130  
Barrington, Il. 6001

**Credit Card Authorization Form**

By signing this form you allow the office to retain your credit card information to be used to cover copays, deductibles, or self pay amounts. All information given to the office is kept strictly confidential for internal use only.

**I authorize Dr Kuo to use my card for any outstanding balances or fees as stated above. I also authorize that this card be kept on file for further follow up appointments and that if the card becomes invalid or expired, it is my responsibility to update the office on a different form of payment.**

**Type of Card:    VISA            MC            AMEX            Discover    Debit**

**Name on Card:** \_\_\_\_\_

**Card Number:** \_\_\_\_\_

**Exp Date:** \_\_\_\_\_                      **Security (CVV) Code:** \_\_\_\_\_

**Signature:** \_\_\_\_\_                      **Date:** \_\_\_\_\_