IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Preauthorized Healthcare Payment Form

I understand that Adult Immunization & Travel Clinic, San Francisco Dept. of Public Health (AITC), will submit claim(s) to my healthcare insurance company for the charges incurred and I hereby authorize **AITC or its designee, ZirMed Inc. / Elavon Inc.,** to charge my Visa, MasterCard, or Discover, as indicated below, for the entire remaining balance of the charges that are not paid to AITC by my healthcare insurance company.

This authorization includes balance charges for initial and follow-up visit(s) from:

Today's date _____ /_____ /_____ through 1 month from today (_____ /_____ /_____)

Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Last 4 digits of Card Number **XXXX-XXXX-XXXX-**☐☐☐☐ **(required)**

Expiration date: ☐☐ ☐☐

Last 4 digits of Card Number **XXXX-XXXX-XXXX-**☐☐☐☐ **(optional/ secondary)**

Expiration date: ☐☐ ☐☐

Patient Name _____

Cardholder Name (if different than Patient) _____

Cardholder Billing Address _____

City, State, Zip _____

_____

Card Holder's Signature ***Date***

101 Grove Street, Suite 102, San Francisco, CA 94102
Phone (415)554-2625 | Fax (415)554-2619 | www.TravelClinicSF.org