

East West Integrative Medicine

Pre-Authorized Healthcare Form

I authorize **East West Integrative Medicine** to keep my signature on file and to charge my credit card account as indicated below:



Balances of charges not paid by insurance within 90 days and not to exceed \$ _____ .

For (check one) All Visits This Visit

Reoccurring Charges (on-going treatments)

Of \$ _____ Each _____ From _____ To _____
Frequency Date Date

Patient's Name _____

Cardholder's Name _____

Cardholder's Billing Address _____

City _____ State _____ Zip _____

Account Number

Expiration Month Expiration Year

I understand that this form is valid for 1 year unless I cancel the authorization through written notice to **East West Integrative Medicine**.

Cardholder Signature _____ Date _____

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