Piedmont Internal Medicine, Pulmonary and Infectious Diseases, P.A.

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AUTHORIZATION FORM FOR NEW PATIENTS

Patient Name ____

Date of Birth ____

Credit Card# ____

Expiration Date ____

CVV# ____

Zip Code ____

By signing this form, I am giving permission to Piedmont Internal Medicine, Pulmonary and Infectious Disease, P.A., to charge my credit card the amount of **$50.00** if I do not show up for my appointment.

Signature ____

*Note: All this information will be shredded when the patient shows up for the appointment, and we will not keep it in the chart.