

## REVOLVING CREDIT AUTHORIZATION

I, \_\_\_\_\_ (Patient name) authorize  
\_\_\_\_\_ (Doctor Name) to apply to  
my credit card any balance owed on my account for the patient(s)  
listed below.

The chargeable amount is not to exceed \$ \_\_\_\_\_ per  
\_\_\_\_\_ (week/month).

This balance may be the result of a co-pay, deductible, non-  
covered service or the lack of notice from an insurance carrier, etc.  
Please note that the name ***Plexus*** will appear on your monthly  
credit card statement.

This payment method will remain in effect until I revoke it in  
writing and mail it to: Plexus Health Solutions, Inc.  
P.O. Box 0655  
Kenosha, WI 53141-0655

Visa    or    MasterCard    (circle one) (No medical flex cards are accepted)

Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

The above payment method will cover open balances for all of the following family  
members:

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