



Head and Neck
S U R G E R Y
A S S O C I A T E S , P S C

Electronic Charge/Debit Authorization Direct Payment Enrollment for Bill Payment

Online Payment Processing Available www.nkyent.com

Name of Financial Institution _____

Account Number _____

Expiration Date _____ 3 Digit Security Code _____





Name as it appears on card _____

Billing Address _____

Daytime Phone Number _____

Cardholder phone _____

Please charge my credit/debit account as follows:

<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 
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By my signature below, I authorize Head and Neck Surgery Associates, PSC or Center for Surgical Care to process my credit/debit card the following payment indicated below. I understand that if I decide to discontinue this payment plan I will send notification in writing to HNSA, 40 N Grand Ave, Suite 101, Fort Thomas, Kentucky 41075.

- One time charge in the amount of \$ _____
- My balance due after my insurance processes a claim for date of service
- Monthly charge in the amount of \$ _____
- This authorization is not to exceed \$ _____ (maximum)

Print Name	Signature	Date
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Mail 40 N Grand Ave, Suite 101, Fort Thomas KY 41075, Fax (859) 572-3039, Email Billing @nkyent.com or Drop Off