COMPLETE CARE CENTER
EMERGENCY & FAMILY CARE WITH A Heart

Company Account Information

For work physicals/drug testing/work treatment

PLEASE RETURN FORM BY FAX TO 810-771-2158 ATTN THERESA

Authorized Company Signer Information

Business Name			
Last Name	**First Name**	**Middle Initial**	
Billing Street Address	**Billing City**	**Billing State**	**Billing Zip**
Business Telephone #	**Cell Telephone #**	**Fax #**	
Email Address (Receipts for payments will be emailed to this address only)			

Authorized Company Representative to Receive Testing/Treatment Results

Reports will only be submitted to the person and fax number listed below.

First Name	**Last Name**	**Fax Number**

Please complete the information below:

I _____ authorize Complete Care Center to charge my account indicated below for payment of medical care received by my employees or potential employees. I understand that there will be a $30.00 charge for each NSF, chargeback or correction of credit card failure.

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

I agree to notify Complete Care Center in writing of any changes in my account information or termination of this authorization. Signer authorizes Complete Care Center to debit the account for all sums owing to Complete Care Center including any NSF, chargeback or correction of credit card failure fees ($30.00 per). I am responsible for full payment of "Time of Service" fees at the time of service. I also release Complete Care Center from any billing issues in the future with insurance companies or others concerning "TOS charges.

SIGNATURE _____ DATE _____

8401 Holly Road
Grand Blanc, MI 48439
O: 810-695-8011 F: 810-695-8002
admin@completecarecenter.net