DEBIT / CREDIT CARD PAYMENT AUTHORIZATION

PATIENT NAME: _____ DOB: _____

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee or service may be denied for failure to pay a co-pay or any outstanding balance at the time of service.
4. I understand that it is my responsibility to ensure that the Provider has current information on file, at all times, including my address, contact details, insurance information, and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that the Provider may offer an automated payment plan option, if available, and that this convenience may incur interest charges.
7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) co-insurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. I understand that I may receive a monthly statement for any outstanding balance that is not satisfied by a charge to my payment method and that I am responsible for paying this balance by its due date.
9. I understand that unpaid balances may incur additional fees and interest charges.
10. I understand that I may not be provided with advance notice of authorized payments and any advance notice that is given is done so as a courtesy of the provider. Transactions will be maintained in patient file.
11. I authorize the Provider and/or its designated payment agent to send electronic account statements, invoices, and receipts to the email address I have provided to this office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
12. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to the Provider.

ACKNOWLEDGMENT AND AUTHORIZATION:

By signing this form (i) I acknowledge that I have received, reviewed, and understand the Provider's payment policies, (ii) I authorize the Provider and/or its designated payment agent to charge my credit/debit card in accordance with the payment policy, and (iii) I certify that I am an authorized cardholder or user of this credit/debit card.

Name on Card: _____ Email Address: _____

Credit Card # _____ CVV: _____ Billing Zip Code: _____

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Other _____

_____ _____

Cardholder's Signature Date