



Credit Card on file

Credit Card on File Policy

As of July 15, 2013 for your convenience, we have implemented a policy which enables you to maintain your credit card/debit card information on file with us. With your consent, this information will be securely held to cover future charges and additional fees.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease our cost to generate and send out statements. This combination will benefit everybody in helping to keep the cost of healthcare down.

I have read and fully understand the contents of the "Credit Card on File Policy."

Patient Name _____ Date: _____

Patient Signature: _____

Credit Card On File Consent

I hereby authorize Premiere Medical Center to keep my card information on file for payment of any and all charges for medical services for which I am financially responsible and that remain unpaid after applying insurance payments and adjustments, if any. Co-payments due at the time of visit will, of course, still be due at the time of the visit. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charged will be emailed or mailed to you.

Signing this consent in no way compromises your ability to dispute or question your insurance company's determination of payment.

Patient signature: _____ Date: _____

Patient name: _____ DOB: _____

Credit Card Information

I authorize Premiere Medical Center to charge outstanding balances on my account up to (balance in full/ \$ _____) to the following credit card:
(amount limit/transaction)

Visa Master Card American Express Other: _____

Credit Card Number : _____ Expiration Date: _____

Billing address: _____

Patient name: _____ Signature _____