Patient Credit Card on File Agreement

Preauthorized Credit

We have implemented a policy which enables you to maintain your credit card information securely on file with **Carolina Pediatric Surgery**. In providing us with your credit card information, you are giving **Carolina Pediatric Surgery** permission to automatically charge your credit card on file for your co-pay, deductible etc. at the time of service. By signing this agreement you authorize it to remain in effect until the expiration of the credit card account. You may revoke this form at any time by submitting a written request.

Co-pays, Deductible etc.*:* Co-pays & deductible (not met) are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, **Carolina Pediatric Surgery** will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize ___Carolina Pediatric Surgery_____, to charge co-pays and outstanding balances on my account to the following credit card:

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Card number _____ CVV number: _____

Expiration Date: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient Signature: _____ Date: _____