Spring
ENDOCRINOLOGY

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CREDIT CARD ON FILE AGREEMENT

IN NETWORK PATIENTS

Your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. Balances owed will be applied to the card on file. These transferred amounts are outlined in the Explanation of Benefits (EOB) that is mailed to you by your insurance company. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

OUT OF NETWORK PATIENTS

All balances are due at the time of service. The card on file will be charged accordingly the day of your visit.

By signing below, I authorize Spring Endocrinology to keep my signature and credit card information securely on file in my account. I authorize Spring Endocrinology to charge my credit card for any outstanding balances when due.

If the credit card I give today changes, expires, or is denied for any reason, I agree to immediately give Spring Endocrinology a new and valid credit card which I will allow them to charge over the telephone. Even though Spring Endocrinology is not processing the new card in person, I agree that the new card may be used with the same authorization form according to the terms outlined above. I certify that I am an authorized user of the credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. Should you wish to revoke this authorization at any time please send written notice to the office.

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Patient Name(Print): _____ DOB: ___/___/_____
Name on Card (Print): _____
Credit Card # _____ Exp Date: ____/____ Security Code: _____

Please fill out the information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____

Card Holder's Signature: _____ **Date:** _____