Credit Card on File Authorization

Patient: ______________________________________ Account #: ______________

AGREEMENT

Until further notice, I authorize Digestive Disorders Associates, Maryland Diagnostic & Therapeutic Endo Center, and Maryland Anesthesia Providers to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa Mastercard Discover A/E

Type: Credit HSA FSA

Card Number: ____

Exp. Date (mm/yy): ________________________

3 Digit Security Code: ____________

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from my insurance company. The insurance plan EOB will state any balance remaining to be paid by me. I agree that my credit card on file may be charged for the balance due at the time the copy of the EOB is received by the provider.

Signature: __________________________________ Date: ________________

Printed Name of Cardholder: _______________________________________

Date of Birth: __________________ Last 4 digits of SSN: ________________

NOTE: *Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.*

Last Updated 7/19/2016