



Authorization for Credit Card on File Payments

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.

AUTHORIZATION

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: _____

Date of Birth: _____ Last 4 digits of SSN: _____

Email, if you would like an email receipt: _____