

Digestive Specialists, PA

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Patient Credit Card Consent for Office Visits & Procedures

Due to continued cuts in reimbursements, the cost of mailing statements and increased postal rates, we ask that you leave a credit card on file for any unpaid balances for today's visit or any services scheduled within 1 year of the date signed, including any out patient procedures that may be scheduled.

I hereby authorize Digestive Specialists, P.A. to keep my signature on file and to charge by credit card for the account balances **not to exceed the billed charge.**

Patient's Name _____ Date of Birth _____

__ MasterCard __ Visa __ Discover __ American Express

Account #: _____

Expiration Date: _____ Signature Code: _____

Cardholder name as it appears on card: _____

Cardholder address: _____

Cardholder phone #: Home _____ Other _____

I understand any fee(s) quoted to me is an estimate and the actual charges may be higher or lower and will be adjusted upon receipt of the Explanation of Benefits. Please be aware that we must have payment on file prior to the start of your services or your appointment may be rescheduled.

I, the undersigned, certify that I have read the foregoing, I am the patient or duly authorized by the patient as the patient's general/legal agent to execute the above and accept its terms.

Patient Signature

Date