PRINT PATIENT NAME _____

PATIENT BIRTHDATE _____

I authorize Advanced Integrative Healthcare, SC to charge co-pays, no-show fees, and/or outstanding balances on my account to the following credit card:

Credit Card on File Agreement

In our efforts to improve patient service and office efficiency, we have implemented a policy which enables you to maintain your credit card information securely on file (not in the computer) with Advanced Integrative Healthcare, SC (AIH). We are PCI compliant for credit card storage. In providing us with your credit card information and signing this form, you are giving AIH, SC permission to automatically charge your credit card on file for your co-pay, no-show fee, or outstanding patient balance **TWO WEEKS** after insurance has adjudicated your claim. As a courtesy, you will be sent a billing statement when a balance becomes due.

□ **HSA/FSA** □ **Visa** □ **MC** □ **Discover** □ **Debit**

Credit Card Holder's Name (print): _____

CC Number: _____

Exp Date _____/_____ Zip Code _____ CVV _____

What if I have a debit card or HSA? How will I know exactly when the charge will be put through?

You are notified by your insurance company of any patient portion due by you. We also send you a statement after which you have TWO WEEKS to review and pay your balance with your preferred payment. If we do not hear from you within the two weeks, we assume you are in agreement with your balance and prefer we use your credit card on file. If you would like a credit card receipt, you are welcome to call our office and request it within 60 days of the charge.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. We recommend you contact your insurance company first with any insurance discrepancies.

DECLINED CARD: **Any card that is declined is subject to a $35.00 fee, regardless of the balance as well as late fees that apply to an overdue balance.** It is my responsibility to make sure the card on file is valid and accurate. I will notify AIH as soon as possible with any card information changes. In the event that there are any problems with my credit card payment, I agree to pay all collection costs and reasonable attorney's fees incurred in attempting to collect on the account balance.

I certify that this is my credit card and that I am legally authorized to give permission for its use by AIH for my balances on my account.

SIGNATURE: _____ Date: _____

OFFICE USE ONLY

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ADVANCED INTEGRATIVE HEALTHCARE, S.C.
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