Advanced OBGYN Financial Policy

(Effective August 1, 2014)

Authorization for Card on File

Patient name:_____

Cardholder/Checking Account name:_____

Account Holder's Address:_____

Account Holder's City:_____ State:_____ Zip:_____Phone #:_____

E-Mail Address (to receive receipts):_____

If you would like to leave a credit/debit card on file, please fill out the following:

Type of card (circle one): VISA AMEX MASTERCARD DISCOVER

Card Number:_____ Expiration date:_____

Security Code (last 3 numbers in signature blank on card…4 cards above number on AMEX):_____

I hereby authorize Advanced OBGYN and Heartland Payment Systems to store my payment information securely on file and to make charges to the payment method as outlined in the financial policy above. The charge will be based on the medical treatment rendered to me (or my dependent) and the usual customary charges made by Advanced OBGYN for such treatment and service. If payment is denied by my credit or debit card company or other financial institution, I will pay the entire amount within thirty (30) days.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by all physicians of Advanced OBGYN and agree that if the office places my account with an agency or attorney for collection, Advanced OBGYN shall be paid by me for all of its costs and expenses in collecting monies owed to them to the extent allowed by applicable law. Those expenses include, but shall not be limited to, attorney's fees, court costs, and other expenses incurred with collection of my account by an agency or attorney.

_____ _____

Signature of Responsible Party Printed Name

_____

Today's Date

If you have a question about the Card On File policy, please ask to speak to a member of our business staff and they will be glad to assist you.