John T Armstrong Jr MD Inc
Credit Card Authorization Form
(Mandatory for all patients)

Patient Name: _____ Date of Birth: _____

The purpose of this form is to authorize **John T Armstrong Jr MD Inc** (JTA) to retain a valid credit card number on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. JTA reserves the right to charge the credit card listed below monthly for all current patient balances under *$500.00*, including co-pays, deductibles, co-insurance and charges not allowed by your insurance company. A receipt will be sent to your current address on file or emailed if you provide a valid email address. This notice serves as your consent to being charged for all current patient balances per above on your account. *A representative from JTA will contact you regarding balances over this amount either via a phone call, email or statement.*

2. Other than the conditions mentioned above, under NO circumstance will JTA charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within our secure credit card program. Once your information is entered into the system no one will be able to access your full credit card number or CVV information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____ X_____
Patient Signature Date

X_____ X_____
Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD: _____
BILLING ADDRESS: _____

Please provide your card to the receptionist, she will enter the information into our secure system and return the card to you. No physical copy of your credit card # or CVV will be maintained in the office.

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with JTA, JTA will require prepayment of any estimated patient responsibility after your insurance pays or full fee if you have no insurance coverage. You also agree to pay any remaining balances due after prepayment and insurance payment within 30 days.

X_____ X_____
Patient Signature Date

X_____ X_____
Staff Signature Date