Peter Grant, M.D.

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Credit Card Authoriztion Form

PATIENT NAME:_____ _____ DOB:_____

The purpose of this form is to authorize Peter Grant, MD to retain a valid credit card number on file for you as my patient. This form will be kept confidential and only authorized staff will have access to the information.
Your suppled credit card will be charged ONLY under the following circumstances:

1. Peter Grant, MD reserves the right to charge the credit card listed below for all current patient balances, 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. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appoitment without 24-hour notice to cancel or reschedule, Peter Grant, MD reserves the right to charge the credit card listed below $25.00 for our standard no-show fee and a recipt will be sent to your current address on file. This notices serves as your consent to being charged a no-show fees, excluding a written doctors excuse, police report, etc in the event of unavoidable emergencies. As is customary, a representative from Peter Grant, MD will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appintment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.
3. If we receive notice that a payment is returned to us for any reason, Peter Grant, MD reserves the right to charge the redit card listed below a $30.00 returned check fee as well as a $25.00 processing fee. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.
4. If you, as the patient receives a Fee for Service, this includes any labs, procedures, and other services not covered by your insurance and offered to you by Peter Grant, MD, we reserve the right to charge the credit card listed below the cost of ther services rendered. This notice serves as your consent to being charged for the cost of services rendered.
5. Other than the conditions mentioned above, under NO circumstances will Peter Grant, MD 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 your medical chart in my office. Only authorized staff will be able to access this 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.

_____ _____

Patient Signature Date Staff Signature Date

Name as it appears on Credit Card: _____

Billing Address:_____

Credit Card Number:_____

Expiration Date: _____ V-Code:_____

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with Peter Grant, MD, we reserve the right to send only **2** statements to the address on file to notify you of your balance with our practice. Please note, it is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with my practice.

_____ _____

Patient Signature Date Staff Signature Date