



LIFE IN BALANCE

OSTEOPATHIC MEDICAL CENTER, PLLC

Authorization to Charge Card on File

Patient & Cardholder Information	
Patient Name:	Cardholder Name (if different than patient):
Email (for receipts):	Relationship to Patient:

Card Information		
Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Amex <input type="checkbox"/> Discover <input type="checkbox"/> HSA/FSA		
Last 4 digits of Card:	Exp Date (MM/YY):	CVV (Sec Code):

Authorization Terms:

I authorize **Life in Balance Osteopathic Medical Center** to securely store my credit card information and charge it for the following purposes and understand that I will **receive an emailed receipt** after each transaction:

- **Copayments, Coinsurance, and Deductibles** - To cover out-of-pocket expenses as determined by my insurance provider.
- **For self-pay services**, generally immediately after completion of care, but in some cases, charges may be processed up to 48 hours following the date of service.
- **For miscellaneous office fees**, for example: missed appointments, late cancellations, completion of forms, and preparation of letters. Patients will be notified prior to charge.

Charge Authorization Preferences (Please select one):

- Automatically** (without notification): Within 24 bus hrs. of appointment for all 'Self Pay' patients.
- Automatically, **after insurance has processed** for charges that are deemed my responsibility such as: co-pays, co-insurances, deductibles, and non-covered services, etc.
- I will authorize after being notified via: **text message** or **emailed statement**

Terms and conditions:

- I understand that statements will be sent to my portal account prior to payments if I have an active one. Otherwise, I realize that I may request detailed charge history at any time.
- I agree to notify the office immediately if my card information changes or if I wish to revoke this authorization.
- I certify that I am the authorized user of the credit card listed above and that I agree to the terms outlined in this form.

Signature of patient or cardholder:	Date:
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