EASTERN SHORE PRIMARY CARE
EXCEPTIONAL PREVENTATIVE AND MANAGED CARE

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Credit Card Authorization Form

Authorization for Credit Card Use

I authorize Practice Name, to retain my credit card information on file and use the credit/debit card information that I have provided to manually charge my credit card for any of the following circumstances:

1. Missed appointment (neglect to cancel an appointment within 24 hours' advanced notice) per the rates listed in the financial agreement.
2. No-shows or late cancels
3. For any insurance copay, coinsurance, deductibles
4. For any services provided if I am unable to pay at the time of the appointment
5. If I do not have my current credit card or another method of payment available

By consenting to, digitally signing, and submitting this Credit Card Authorization Form, I attest that I fully understand and agree to its contents and have personally reviewed and accepted all terms and conditions to charge my Credit/Debit Card on file.

Patient Name **Patient Signature** **Date**