CREDIT CARD AUTHORIZATION FORM

We require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance company does not cover, but for which you are liable.

Your credit card information is kept confidential and electronically secure by our Merchant Services. Charges to your credit card are made only after the claim has been filed and processed by your insurer and the insurance portion of the claim has been paid, adjusted, and posted to your account.

I, the undersigned, authorize Eye Institute of Marin to charge the portion of my bill that is my financial responsibility as per the insurance company EOB to the following credit card. Balances of $50 or less will be charged immediately, otherwise I will receive a statement from Eye Institute of Marin for the balance my insurance company determines I owe. A "no-show" fee of $75 for not cancelling or rescheduling my appointment 48 hours prior to the appointment time, will be automatically charged to my credit card. I understand that my credit card will be charged 10 days after the date of statement if other arrangements have not been made.

I agree to notify and update my credit card information as necessary. A fee of $35 will be added to my account if my credit card is denied.

This authorization will remain in effect until I cancel it with a 60-day notification in writing. The account must be in good standing.

Patient Name:	
Credit Card Billing Address:	
Cardholder's Name:	
Credit Card Type	Visa ☐ Master Card ☐ AMEX ☐
Credit Card #:	
Exp. Date:	Security Code:

Patient Signature:_____Date:_____

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