Credit/Debit Card Payment Consent Form

Patient Name ____
Print Last First Middle Initial

Name on Card if different ______________________________________

I authorize _________________________ **and Availity.com**
Provider Name
to charge my card for professional services as follows:

Initial

_______ This visit only, for the amount of $________________.

_______ All visits in the next 12 months, beginning ______ /______ /______,
not to exceed $___________ total.

_______ Recurring charges, date(s) of service ______ /______ /______ to
______ /______ /______, not to exceed $_______________,
_____ monthly, _____ semimonthly, _____ weekly, _____ per visit.

_______ **to charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover Exp. Date ___________

Card Number ________ - ________ - ________ - ________ CVV Number _________

Card Holder's Billing Address for Monthly Card Statements

____
Street City State Zip

If I have questions about these charges, I agree to contact my provider and if necessary availity.com. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _________________________ Date _____ /_____ /_____