Digestive Specialists, PA

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Office: (936) 321-0033 Fax: (936) 321-0032

Patient Credit Card Consent for Office Visits & Procedures

Due to continued cuts in reimbursements, the cost of mailing statements and increased postal rates, we ask that you leave a credit card on file for any unpaid balances for today's visit or any services scheduled within 1 year of the date signed, including any out patient procedures that may be scheduled.

I hereby authorize Digestive Specialists, P.A. to keep my signature on file and to charge by credit card for the account balances **not to exceed the billed charge.**

Patient's Name ____________________________________Date of Birth_______________

__*MasterCard* __*Visa* __*Discover* __*American Express*

Account #:____

Expiration Date: _____________ Signature Code: ___________

Cardholder name as it appears on card: ____

Cardholder address: ____

Cardholder phone #: Home______________________ Other_________________________

I understand any fee(s) quoted to me is an estimate and the actual charges may be higher or lower and will be adjusted upon receipt of the Explanation of Benefits. Please be aware that we must have payment on file prior to the start of your services or your appointment may be rescheduled.

I, the undersigned, certify that I have read the foregoing, I am the patient or duly authorized by the patient as the patient's general/legal agent to execute the above and accept its terms.

____________________________________ ____________________

Patient Signature **Date**

I, the undersigned, am aware that I am leaving a ***DEBIT CARD*** on file, and will be sole responsible for any additional charges from my financial institution, if my card is run for any account balances.

____________________________________ ____________________

Patient Signature **Date**