Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with ***Lea H. Kirkland, MD, PA***. In providing us with your credit card information, you are giving ***Lea H. Kirkland, MD, PA*** permission to automatically charge your credit card on file for your Office Visit [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

OFFICE VISIT: Full charge of office visits are due at time of the office visit.

Outstanding Balance: If you [or any other patient(s) you have listed on this form] have an outstanding balance owed that is over 90 days past due, ***Lea H. Kirkland, MD, PA*** will notify you via mail and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

*I authorize **Lea H. Kirkland, MD, PA**, to charge office visits and any outstanding balances on my account to the following credit card:*

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____ CVC: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Signature : _____ Date : _____

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Patient Signature _____ Date _____

Patient Signature _____Date _____