

Credit Card Authorization Form

Tompkins & Assoc. requires that all patients have a credit card on file. Although our office policy is to collect co-payments and deductibles as services are incurred by cash or check, this card on file conveniently assists in the collection of patient responsibilities for fees that are past due 60 days. Account numbers are kept secure. You may also revoke this agreement in writing at any time. Your cooperation is much appreciated.

Credit Card Information: Please be sure to complete all sections.

1) Card Holders Name: _____

2) Credit Card Number: _____

3) Expiration Date: _____

4) 3 Digit Security Code on back of card (4 digits on front of AmEx): _____

5) Billing Zip Code of Credit Card: _____

4) Type of Card: Visa, MasterCard, AmEx, Discover, Flex spending

5) Card Holders' Signature: _____ Date: _____

6) Card Holder Phone number: _____

_____(initial) I understand that by signing above, I am authorizing Tompkins & Assoc. to charge my credit card for balances 60 days past due. These balances may include unpaid co-pays, co-insurance amounts, deductibles, and/or charges for missed/late cancelled appointments. I understand that Tompkins & Assoc. can provide me a statement as well as a receipt for any charges that are applied to the credit card upon request. Tompkins and Assoc. will contact me if my card is declined or expired should I fail to update this information.

Client Signature (12 and over) Date

Guardian Signature (if applicable) Date