

# OPC CREDIT CARD AUTHORIZATION FORM

(Mandatory for all new patients.)

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

The purpose of this form is to authorize Ophthalmic Plastic Consultants (OPC) to retain a valid credit card number on file for you as our patient. **All new patients are required to complete this form.** This form will be kept confidential, and only authorized staff have access to the information. *Please also review the posted Financial Standards & Practices in the lobby.*

Your supplied credit card will be charged ONLY under the following circumstances:

1. OPC reserves the right to charge the credit card listed below for all current patient balances (following insurance payments), and a receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, OPC reserves the right to charge the credit card listed below \$50.00 for our standard no-show fee, and a receipt will be sent to the current address on file. This notice serves as your consent to being charged for any and all no-shows. *As is customary, a representative from OPC will call the phone number on file to remind you of your scheduled appointment. This reminder is usually 1-2 days prior to your scheduled appointment. It is the patient's responsibility to ensure that we have a correct, current telephone number on file.*

Other than the conditions mentioned above, under NO circumstance will OPC charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

## Acknowledged, Agreed, & Accepted:

*Having read this form and talked with the physician and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.*

X \_\_\_\_\_  
Patient Signature Date  
*(or person authorized to sign for patient)*

X \_\_\_\_\_  
Staff Signature Date

**NAME, AS APPEARS ON CREDIT CARD:** \_\_\_\_\_

**BILLING ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**AMEX / DISC / MC / VISA CARD #:** \_\_\_\_\_

**EXPIRATION DATE:** \_\_\_\_/\_\_\_\_ **VERIFICATION CODE (3 or 4 DIGITS):** \_\_\_\_

## Refusal to Complete Authorization:

*Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with OPC, OPC reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. Please note, there may be a discretionary charge of \$10.00 for this statement. It is your responsibility to send the amount due within 45 days of your statement to avoid being sent to collections and having your account closed with our practice.*

X \_\_\_\_\_  
Patient Signature Date  
*(or person authorized to sign for patient)*

X \_\_\_\_\_  
Staff Signature Date