INSTITUTE FOR SPECIALIZED MEDICINE
CREDIT CARD AUTHORIZATION FORM
(Mandatory for all new patients)

PATIENT NAME:_______________________________________DATE OF BIRTH:_______________________

The purpose of this form is to authorize the Institute for Specialized Medicine (IFSMED) 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 will have access to the information. *Please ask front desk for a copy of our Office Policies or see our policy on our website at IFSMED.COM.*

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

1. IFSMED reserves the right to charge the credit card listed below for all current patient balances, including co-pays (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 the patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, IFSMED reserves the right to charge the credit card listed below $25.00 for our standard no-show fee and a receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows. *As is customary, a representative from IFSMED will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*

3. If we receive notice that a payment is returned to us for any reason, IFSMED reserves the right to charge the credit card listed below a $30 returned check fee as well as a $25 processing fee. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.

4. If you, as the patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. IFSMED reserves the right to charge our base fee of $20 to provide you with a copy of your record. This notice serves as your consent to being charged for medical records request.

5. If you, as the patient receives a Fee for Service, this includes any medications, labs, procedures, supplies and other services not covered by your insurance and offered to you by IFSMED, we IFSMED, reserve the right to charge the credit card listed below the cost of the services rendered. *For a list of our fee for service costs, please see the front desk.*

Other than the conditions mentioned above, under NO circumstance will IFSMED 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_______________________________________ X_______________________________________
Patient Signature Date Staff Signature Date
(*or person authorized to sign for patient)*

NAME, AS IT 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 IFSMED, IFSMED 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 $20.00 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