Credit Card Authorization Form

Patient Name: _____ DOB: _____

The purpose of this form is to authorize Arizona Associated Surgeons to retain a valid credit card number on file for you. This information will be kept secure and can only be accessed by authorized staff. Your credit card will ONLY be charged under the following circumstances:

Copays/Coinsurance/Deductible: AAS reserves the right to charge the credit card on file for all patient balances including copays, coinsurance, deductibles and any patient responsibility as directed from your insurance company. A receipt will be sent to you for all transactions. This notice serves as your consent to being charged for all current patient balances on your account.

No Show Appointment Fee: If a patient misses a scheduled appointment in the office without a 48-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $25.00 fee. If a patient misses a scheduled surgery appointment without a 72-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $250.00 fee.

Returned Payment Fee: If we receive notice that a payment is returned to us for any reason, AAS reserves the right to charge the card on file a $40 returned payment fee.

Self-Pay Patients: If you are a self-pay patient without insurance, AAS reserves the right to charge the credit card on file for services performed.

Refusal to sign: In the event you opt not to sign the credit card authorization form you will be required to prepay for all services according to your benefit plan. You will receive **ONE** statement for any remaining balances. If the balance is not paid within 14 days, you will incur a $25.00 service fee for each additional statement.

Other than the conditions mentioned above, under NO circumstances will AAS charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidential and securely kept within our PCI compliant merchant service system. Only authorized staff will be able to access this information.

By signing the credit card authorization form, you understand that as soon as your EOB (explanation of benefits) is received by our office from your insurance company your credit card will be charged for the balance due on your account.

Acknowledged, Agreed, & Accepted. Having read this form, my signature below acknowledges that I give my authorization and consent for my credit card to be charged for the conditions listed above.

_____ _____

Patient Signature Date Staff Signature Date