Credit Card On File Authorization

We understand that convenience is not often associated with today's healthcare environment. Our Practice not only focuses on excellent healthcare service but also how to provide service as cost and time effective as possible. We have found that collecting all known liability at the time of service is not only beneficial to the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit on file to handle any remaining balances after the insurance company reimbursement.
I, _____authorize Aldrich Chiropractic to keep my signature and credit card information on file and to charge my account for balances that remain unpaid including **coinsurance/copays/deductibles** upon the office of Aldrich Chiropractic's receipt of your insurance's **Explanation of Benefits.**

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:_____

Patient Name:_____

Card Holder Name:_____

Card Holder Address:_____

Type of Credit Card: Visa____MC____AMEX_____DISC_____#_____

Expiration Date:_____Security Code:_____

Signature:_____Date:_____