Fairfield Medical Group, LLC

Authorization for Credit Card on File Payment

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION

Until further notice, I authorize Fairfield Medical Group, LLC to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa Mastercard Discover Amex

Last 4 digits of my credit card: ____ ____ ____ ____

Exp. Date (mm/yy):_____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Fairfield Medical Group, LLC may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $ 200, I will receive a courtesy call prior to my card being charged.

Signature: _____ Date: _____

Printed Name: _____

Date of Birth: _____

Email Address (Required for receipt): _____