Patient Sponsor Credit Card On File Agreement

I, ________________________, authorize Physicians Now Urgent Care Center to charge my credit card below, for the service(s) received by ______________________ today and for any patient-responsible balance(s) for the service(s) received after the claim(s) has been processed by his/her insurance company.

My address is:

____

____

Check one: □ Visa □ MasterCard □ Discover

Last 4 digits of my credit card: ___________ Exp. Date (mm/yy): __________

If your balance is over $100 you will receive a courtesy call.

My phone number is: _____________________________

Declined transaction/closed account:

- You will be notified by phone by our billing department to provide alternate card for payment.
- A $50 penalty will be added to all accounts if no alternative payment is provided.
- An additional monthly late fee charge of $25 will also be applied to any account that is 30 days past due from the date of the failed transaction.

Would you like an emailed receipt? □ Yes □No Email: __________________________

□ Delete my credit card information once my claim has been processed and paid.

Note: A new agreement will be needed for each subsequent visit.

□ Leave my credit card information on file for his/her future visits.

Printed Name: ____________________________________

Signature: ________________________________ Date: _________

Please attach a copy of your driver's license.