KEEP CREDIT CARD ON FILE

At Bowie Internal Medicine Associates we now require your credit or debit card on file, a convenient method of payment for any portion of services that your insurance does not cover. This information is kept confidential and secure in our office and payments to your card are processed only after the claim has been filed and the insurance portion of the claim has been paid and posted to your account.

Please provide us with the card information you wish to keep on file:

Card Number:____

Exp. Date (mm/yy):________________ Card Security Code:__________

Cardholder Name:____

Read and Sign the payment agreement:

I, the undersigned, authorize and request Bowie Internal Medicine Associates to do the following actions per the payment method I have chosen.

A. Initiate electronic debit entries or use any other commercially accepted practice to charge my account indicated above in the company/bank named above and I authorize and request company/bank to honor the debit entries initiated by Bowie Internal Medicine and debit these charges to that account.
B. Charge my card, which is indicated above, for my payment. This authorization relates to all payments not covered by my insurance company for services provided by Bowie Internal Medicine Associates. This authorization will remain in effect until all amounts owed are paid in full, or until I cancel this authorization. To cancel, I must give a 60 day notification to Bowie Internal Medicine Associates in writing and I understand that all balances due must also be paid prior to cancellation of this authorization. I understand it is my responsibility to notify Bowie Internal Medicine Associates to cancel the payment information on file, should I wish to terminate this payment option.
C. Payment Plans – an amount agreed upon by the patient and Bowie Internal Medicine Associates will be debited from the card above every week/month until the balance is paid in full

Cardholder Signature:____

Date:________________________