Secure Pay Enrollment Form

By signing this form, you give Huntsville Hospital Urgent Care permission to charge your Credit/Debit/HSA card indicated below up to $300 for any amount not paid by insurance. This authorization applies to each balance prior to or after the date of this authorization. Prior to charging your account, you will receive a notification notifying you of the amount due. Following the receipt of the notification, you will have **10 business days** to contact Huntsville Hospital Urgent Care if you would like to make alternative arrangements for payment. *Services to Include: Office visit and any related services including, but not limited to, Labs, x-rays, injections, any additional ancillaries, etc.*

Please complete the information below:

I______________________authorize_____________________________________(Center Name) to keep my signature securely on file and to charge my Credit/Debit/HSA card indicated below up to $300 for any amount not paid by insurance.

Account Type: Visa MasterCard AMEX Discover

Cardholder Name: ____________________________

Credit Card # (Last 4): __________________

Cardholder Address:__________________________________
(If different than patient)

OFFICE USE ONLY

Patient ID:__________

SIGNATURE____ DATE ______________________

I authorize the above-named business to charge the Credit/Debit/HSA card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card. This authorization expires one year after the above date.