



PHYSICIANS CARE Walk-in Clinic

Secure Pay Enrollment Form

By signing this form, you give Physicians 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 Physicians 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: _____	<u>OFFICE USE ONLY</u>
Credit Card # (Last 4): _____	Patient ID: _____
Cardholder Address: _____ (If different than patient)	

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.