Credit Card on File Billing Authorization Form

Minor Chiropractic Health Center PC requires a credit card be kept on file for payment of any co-payments, co-insurance, deductible or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

I, _____, authorize Minor Chiropractic Health Center PC to capture my credit card information and to charge my credit card as payment for any balance put into the "patient responsibility" as a result of my insurance plan's deductible, co-insurance or co-payment. I understand and agree that this payment will be processed after the claim is finalized and when we receive a copy of the Explanation of Benefits (EOB) from my insurance plan.

I understand and agree that this form is valid until I give a 30-day written notice to cancel authorization to Minor Chiropractic Health Center PC, Attn: Billing Dept, 25520 S. Pheasant Lane, Unit G, Channahon, IL. 60410.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated on this form.

Patient Name: _____

Card Holder Name (as shown oncard):_____

Card Type: _____ Visa _____ Master Card _____ Discover _____ American Express

Credit Card Number: _____

Expiration Date: _____/_____/_____ CCV Code: _____ Billing Zip Code: _____

Cardholder Signature: _____

Additional Family Member Accounts Authorized to Charge Balances to This Card:

_____ _____

_____ _____

_____ _____

For Office Use Only: _____ Date entered into Eclipse