Chopra Pediatrics
1224 7th Ave
Altoona, PA 16602
(814) 944-8784

**Credit Card on File Consent**

Patients First, Middle Initial, Last Name: _______________________________________________

I agree for Chopra Pediatrics to store my credit card on file for all balances due for services rendered during calendar year 2020. I understand my insurance will be billed for this service and any remaining balance is my responsibility to be paid in full after my insurance has processed my claim. I further understand, I will be notified by email of intended one-time transaction, when it will be scheduled and the amount to be transacted which will include a confirmation receipt following once the transaction is final. I also understand that I must list my email at the time of registration for this Date of Service to receive correspondence.

**Automatic Transactions/Practice Default Maximum Transaction:** In agreement the Credit Card on File will be automatically transacted for the patient balance for services rendered during calendar 2020. Your credit card will be transacted at the Practice Default Maximum or full balance as a one-time transaction.

**Our Practice Default Maximum is $100.00.** Any remaining balance due for this date of service that exceeds the Default Maximum will be due upon receipt of the next scheduled statement issued. It is patient/guarantor's responsibility to pay services in full.

**Declined Transactions:** I understand that I am financially responsible for all charges arising for treatment/services rendered will be automatically transacted within 7 days after insurance has processed my claim. I understand that I have a right to request and receive a copy of my Patient Statement and transactions for services rendered. I understand I may access my Patient Statement and transaction records on the secure Patient Portal. I have read the above description of the financial arrangement and agree to its terms.

**Patient Signature:** ______________________________ **Date:** ______________________

**Witness Signature:** ______________________________ **Date:** ______________________