Massard Foot & Ankle Clinic

Dr. Kevin M. Massard, D.P.M.

PATIENT CREDIT CARD FORM

Please initial by each statement
I understand:

_____ It is the Massard Foot and Ankle Clinics' practice policy to obtain credit card information for all new and returning patients.

_____ Massard Foot and Ankle Clinic will keep my credit card information along with my signature on file. ALL credit card information is confidential and safely secured through PayTrace data storage solutions

_____ My credit card will automatically be charged for any missed co-pays or missed appointment fees (i.e. fees that are customarily due on the date services are provided)

_____ Payment plans are available and must be agreed upon in writing.

_____ Patient account balances that are 90 days past due from the date of service will automatically be charged if no payment arrangements have been made. If the card is declined, one courtesy call will be made in an attempt to collect payment. If no payment is received after the final attempt, the account will be forwarded to our collection agency.

Patient's Name: _____

Card Holder's Name: _____

Card Holder's Address: _____

City: _____ State: _____ Zip: _____

Card Type: ____ Visa ____ MC _____Discover

Credit Card Number: _____

EXP Date: _____ CVN security code: _____

Card Holder's Signature _____

Today's Date: _____