James E. Haberman, M.D., F.A.C.S.
Excel Eyecare & Laser Surgery Center

Credit Card on File Agreement

FOR YOUR SAFETY, due to the COVID-19 National Health Emergency, our practice has implemented a new credit card policy. This is a safe, no-touch billing process for the future. We now will ask all patients for a credit card which may be used later to pay any balance that may be due on your bill.

Copays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay in any fashion. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize James E. Haberman, M.D., P.A., to keep my signature and my credit card information securely on-file. I authorize James E. Haberman, M.D., P.A., to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, or expires, please notify the office. If the credit card is denied for any reason, I agree to provide a new, valid card which can be charged over the phone and that the new card may be used with the same authorization as the original card. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

PATIENT NAME: _____ DOB: ___/___/____

CREDIT CARD AUTHORIZATION
VISA or MASTERCARD (Circle one)

NAME (as it appears on credit card) _____

CREDIT CARD NUMBER _____

EXP. DATE ____/____

BILLING ADDRESS OF CREDIT CARD _____
(Where your statement is mailed to)

_____

EMAIL ADDRESS _____

AUTHORIZED SIGNATURE _____ DATE: ___/___/___