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

Credit Card on File Agreement (CCOF)

FOR YOUR SAFETY, our practice has implemented a new credit card policy. This is a safe, no-touch billing process for the future. The office requires all patients for a credit card which may be used later to pay any balance that may be due on your bill.

If you choose not to leave a card or are unable to do so, the office will accept $200 toward the visit. After processing by your carrier, any credit remaining, will promptly be refunded.

Co-pays and deductibles are due at the time of service.

At check-in, your credit card information will be obtained and kept securely. After insurance(s) processes the visit, a statement will be sent and if the balance is not paid within 10 days, the credit card on file will be charged. If there are discrepancies with the carrier, the credit card will be charged as well.

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

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.

PATIENT NAME:____ DOB:_____/_____/_______

CREDIT CARD AUTHORIZATION
VISA, MASTERCARD, OR AMEX (circle one)

NAME (as it appears on credit card)____

LAST 4 DIGITS OF CREDIT CARD NUMBER. PLEASE PROVIDE CARD TO RECEPTIONIST TO SECURELY SCAN INFORMATION INTO OUR SYSTEM ________________________

EXP. DATE_______/_______ CVV (3 DIGIT CODE ON BACK OF CARD)___________
THE OFFICE DOES NOT MAINTAIN PERSONAL CREDIT CARD INFORMATION. IT IS SAVED SECURELY.

BILLING ADDRESS OF CREDIT CARD____
(Where your statement is mailed to)
____

EMAIL ADDRESS:____

AUTHORIZED SIGNATURE_____________________________________ DATE ___/___/__