# Credit Card Information Form, EDI

## To Our Patients:

In an effort to combat rising healthcare costs, we have recently implemented a policy where you will be asked for a credit card number at the time of check in. The information will be held securely until services are rendered. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you upon your request.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well since it will greatly decrease the number of statements that we have to generate and send out. This in no way will compromise your ability to dispute a charge.

If you have any questions about this policy, do not hesitate to ask us.

**OFFICE USE ONLY:**

PATIENT ACCOUNT#:_____ SPOUSE/PARTNERS ACCOUNT#:_____

## Credit Card Information:

Please complete all fields below sign and date:

□ **Visa** □ **MasterCard** □ **Discover** Spouse/Partners Name:_____

**Patient Name:** _____ □ I also authorize charges to be paid

**Credit card #** _____ out for my spouse/partners account.

**Expiration Date:** _____ ___ **please initial your authorization**

**Card Holder Name:** _____

(please print clearly)

**Address Card is Billed To:**

_____

## AUTHORIZATIONS AND PAYMENT AGREEMENT

I hereby authorize payment to be made to Craig R. Sweet, M.D. and Embryo Donation International (EDI) for any service I receive at EDI. I understand that I am responsible for any balance on my account. I hereby authorize Craig R. Sweet, M.D. to charge my credit card with my responsibility for services rendered. I further understand that, if I have provided a debit card and such charges to my bank account should result in an overdraft, I will hold harmless Dr. Sweet and his office personnel of any and all related fees that my bank would assess.

**Print Name:** _____

**Patient Signature:** _____

**Card Holder Signature:** _____ **Date:** _____

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