

RALEIGH ENDOCRINE ASSOCIATES

ENDOCRINOLOGY DIABETES & METABOLISM

Credit Card On-File Authorization:

Until further notice, I authorize Raleigh Endocrine Associates to keep my signature on file and to apply charges to the credit card, debit card, or health savings account card listed below for patient-responsible balances on my account.

I understand that the maximum amount to be charged to my credit card will be \$300.00. If the balance due is more than \$300.00, I will receive a courtesy call to discuss the remaining balance prior to my card being charged.

I understand that I must contact Raleigh Endocrine Associates if there are any changes to my credit card information to include, but not limited to, card expiration, lost/stolen cards, credit limit reached, card reissue, or any additional reason that might affect proper processing of the card on file. I understand that should attempts to charge my credit card for patient responsibility amounts as assigned by my insurance carrier be declined for any reason, I will receive statements for the balance due and, as with any negligent patient balances due to Raleigh Endocrine Associates, my account may become eligible for turnover to a collections agency if I fail to respond in a timely manner.

Type of credit card:

Visa

American Express

MasterCard

Discover

Last 4 Digits: _____ Expiration Date (MM/YY): _____ CVV: _____

Printed Name (as appears on card) _____

Authorized Signature: _____ Date: _____

All credit card information will be stored with PayLeap, a secure credit card processor that partners with Raleigh Endocrine Associates to collect payments.

Office Use Only:

Patient #