Payment Authorization Form

Schedule your payment to be automatically deducted from your Visa, MasterCard, American Express or Discover Card is a convenient way to pay your medical bills, and in most cases will reduce the cost of mailing a payment. Just complete and sign this form to get started!

Here's How Automatic Payments Work:
You authorize Cary Orthopaedic to charge your bank card or credit card for any copay, coinsurance or deductible expenses incurred for treatment received by one of our healthcare providers. You will be charged the amount deemed your responsibility by your insurance company for each visit. You agree that no prior-notification will be provided, other than the EOB you receive from your insurance company. You understand that you will receive an email notification telling you the date of the transaction and the amount that was charged to your account.

Please complete the information below:

I _____ authorize Cary Orthopaedic to
(Full Name)
charge my bank/credit card indicated below for any copay, deductible or coinsurance balance on the following account/accounts:

Acct#_____ Acct#_____

Acct#_____ Acct#_____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Bank/Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Card Holder Name_____

Last 4 digits of the Card Number_____

Expiration Date_____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Cary Orthopaedic in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Cary Orthopaedic may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Office Use Only:
ID verified by: _____ Updated 10/4/18-mlw