BOSTON A+ ABILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with MOTION LLC dba The Boston Ability Center. In providing us with your credit card information, you are giving The Boston Ability Center permission to automatically charge your credit card on file for your child's co-pay or self-pay amount [or for any other children listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays and Self-Pay*:* Co-pays and self-pay amounts are due at the time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your child's bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, The Boston Ability Center will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize The Boston Ability Center, to charge co-pays and outstanding balances on my account to the following credit card:

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Last 4 digits of Credit Card: _____

Expiration Date: _____

Please present your credit card to the front desk to be added to our system.

I authorize that this credit card remain on file for each patient listed below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Cardholder/Parent Signature: _____ Date: _____

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