GREAT RIVER | CHIROPRACTIC & WHOLE BODY HEALTH

Credit Card on File Agreement

I, _____, authorize Great River Chiropractic Clinic to keep a credit card on file to satisfy my financial obligations as defined by Great River Chiropractic Patient Financial Agreement. I understand that my information is stored safely and securely in a HIPAA compliant manner. I understand that Great River Chiropractic will automatically contact me at least 24 hours prior to using this credit card on file if my balance exceeds $150. Any balances under $150 will be automatically processed without notification. If Great River Chiropractic is unable to reach me using the phone number I provide, or in the event that I am unable to satisfy my patient balance Great River Chiropractic will use this credit card on file to resolve any past due balances. It is my responsibility to notify Great River Chiropractic of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Patient Date of Birth: ___/____/_____

Card Holder's Name:

_____
(As shown on credit card)

Credit Card Number to be put on file:

_____

Expiration Date: _____ CV Code _____

Check all that apply:

- ☐ Visa
- ☐ Mastercard
- ☐ Is this a HSA/FSA?

Credit Card Billing Address:

_____

City, State, Zip:

_____

I certify the following CCOF information was collected and the above necessary information has been safely stored for this patient.

Name of Employee Collecting Information (printed): _____ Date: _____

Margaret Winters, DC, BCAO

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