A division of Eastern Carolina Anesthesia Associates, PLLC

Credit Card on File

Midtown Pain and Spine Clinic requires a credit card on file for paying for the portion of your services that insurance has deemed patient responsibility such as copays, deductibles and co-insurance. Your credit card information will be kept confidential and secure.

I, the undersigned, authorize Midtown Pain and Spine Clinic to keep my signature on file and to charge my credit card for the balance due that my health plan has identified as my financial responsibility.

This authorization relates to all charges not covered by my insurance company for services provided to me by Midtown Pain and Spine Clinic. I understand that this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying my charges in full at the time of service of making alternative arrangements for payment.

Patient Signature: _____ Date: _____