Auto Pay Withdrawal Authorization

I, _____, hereby authorize Texas Diabetes & Endocrinology, P.A. to debit my credit card for any amount that is in my responsibility. Texas Diabetes & Endocrinology, P.A. will file my claim to my insurance on my behalf (if applicable- please see Private Pay Agreement). Once the patient responsibility portion has been determined, Texas Diabetes & Endocrinology, P.A. will charge my credit card on file for the amount due and email me a receipt of payment. I understand that I may still be able to dispute said charge at any point up to 90 days from the date of service. I also may request that if the amount due exceeds a certain limit that I be called prior to deducting payment from my card.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Email Address Phone Number

Credit Card Information

I understand that this authorization will take into effect until I cancel it in writing. I agree to notify Texas Diabetes & Endocrinology, P.A. in writing of any changes in my account information or termination of this authorization. I certify that I am an authorized user of this account.

Card Type: **We do NOT accept AMEX or Care Credit.*

☐ VISA ☐ MasterCard ☐ Discover

Cardholder Name (as it appears on card): _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____