NorCal Integrity Surgery

Payment Card Authorization

Patient: _____ DOB: _____

Cardholder (if different): _____

Card on file — last 4 digits: _____ Exp: _____

(Full card number is stored securely by the practice's payment processor and is not recorded on this form.)

I authorize NorCal Integrity Surgery to retain this payment card on file and to charge it only for amounts I owe as my determined patient financial responsibility after my insurer has adjudicated the claim, subject to the terms below:

1. Trigger: The card will be charged only after my insurer processes the claim and my final responsibility is known — never before, and never for an estimated amount.
2. Statement first: I will first receive an itemized statement of the amount owed.
3. 30-day window: I will have 30 days from the statement date to pay, request a payment plan, or request an extension.
4. Advance notice: If I do not pay or respond within that window, I will receive notice that the card will be charged in 7 days unless I contact the office.
5. Cap: The maximum that may be charged to this card without a new authorization is the estimated patient responsibility shown on my good-faith estimate, plus 25%. Any amount above that requires my separate approval.
6. Medicare patients: Charges will reflect only the cost-sharing shown on my Medicare EOB; no amounts will be collected beyond my actual determined responsibility.
7. Revocable: I may revoke this authorization in writing at any time; revocation does not cancel amounts already owed.

Signature: _____ Date: _____