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Credit Card Information Form and Agreement

I, _____, agree to allow About Care OB/GYN Associates to charge my credit card with any remaining balance on my account, **after** my insurance has notified them of the amount of my share for my gynecological visits.

I understand that my information will be kept securely in my chart, guarded with the same level of security as the rest of my privileged information.

If I am unable to present a credit card, I agree to pay a “retainer” fee of \$500.00 that will be held and used to pay receivable amounts as they are due.

Signature

Date

Please select from the following:

VISA

MasterCard

Please complete the information for the card you selected:

Acct Number: _____

Exp. Date: _____

Signature: _____

Date: _____