



301-330-0006

301-330-0444

info@alldaymedicalcare.com

AllDayMedicalCare.com

702 Russell Avenue, Suite 100
Gaithersburg MD 20877

3915 Ferrara Drive
Silver Spring, MD 20906

3508 Worthington Blvd, Suite 101
Urbana, MD 21704

5525 Twin Knolls Road, Suite 323
Columbia, MD 21045

CREDIT CARD AUTHORIZATION FORM

Patient Name: _____

Date of Birth: _____

The purpose of this form is to authorize Family Care Associates (DBA All Day Medical Care Clinic) to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information.

As protocol, we require a credit card on file for all of our patients with the exception of Medicaid patients. Medicaid patients are exempt from any and all out of pocket fees.

Your supplied credit care will be charged ONLY under the following circumstances:

1. Family Care Associates (DBA All Day Medical Care Clinic) reserve the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments), co-insurances and deductibles. A receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Family Care Associates (DBA All Day Medical Care Clinic) reserves the right to charge the credit card listed below \$100.00 for our standard no-show fee. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any and all no-shows and cancellations. *As is customary, a representative from Family Care Associates (DBA All Day Medical Care Clinic) will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*
3. If we receive notice that a payment is returned to us for any reason, Family Care Associates (DBA All Day Medical Care Clinic) reserves the right to charge the credit card listed below a \$35.00 returned check fee. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any returned payments.

Acknowledged, Agreed & Accepted

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

Card Holders Name: _____

Credit Card Number: _____

Expiration Date: _____

CVV: _____

Patient Signature: _____

Date: _____

If patient is a Minor, Parent/Guardian signature below

Parent/Guardian Signature: _____

Date: _____