SHARMA
PLASTIC SURGERY

Credit Card on File Authorization Agreement

Practice Name: Sharma Plastic Surgery
Patient Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____

Authorization

I hereby authorize Sharma Plastic Surgery ("the Practice") to securely store my credit or debit card information on file. I understand that maintaining a card on file is part of the Practice's financial policy and supports timely payment for services provided in accordance with professional medical practice standards, including those required by AAAASF accreditation.

I authorize the Practice to charge my card on file for amounts due, including but not limited to copayments, coinsurance, deductibles, self-pay services, cosmetic services, non-covered services, missed appointment or late cancellation fees (if applicable), and any outstanding balances remaining after insurance processing.

Notice Prior to Charge

Except in cases where payment is due at the time of service, I understand and agree that the Practice will make reasonable efforts to provide advance notice prior to charging my card for any balance due. Notice may be provided via phone call, voicemail, text message, email, mailed statement, or secure patient portal communication.

If I do not dispute the balance or make alternative payment arrangements within the timeframe specified in the notice, I authorize Sharma Plastic Surgery to charge the card on file for the outstanding amount.

HIPAA and PCI Compliance

I understand that my card information will be stored and processed in compliance with applicable Payment Card Industry Data Security Standards (PCI-DSS). Card data is maintained in a secure, encrypted environment and is accessible only to authorized personnel.

I further acknowledge that my personal and financial information is handled in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Payment information is used solely for billing and payment purposes and is safeguarded consistent with federal privacy and security regulations.

Cardholder Responsibilities

I certify that I am the authorized cardholder or have legal authorization to use the card listed below. I agree to promptly notify the Practice of any changes to my card information. I understand that declined or expired cards may result in delayed payment and may require alternative payment arrangements.

I understand that I may revoke this authorization in writing at any time. Revocation will not apply to charges incurred prior to the date the written revocation is received by the Practice.

Card Information (Stored Securely)

Name on Card: _____

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Last 4 Digits of Card: _____

Expiration Date: ____ / ____

Acknowledgment and Signature

I acknowledge that I have read, understand, and agree to the terms of this Credit Card on File Authorization Agreement.

Patient/Cardholder Signature: _____

Printed Name: _____

Date: _____

This authorization remains valid unless revoked in writing.