

Patient First®

Center #: _____

Account #: _____
[to be completed by Patient First staff]

Credit Card Authorization Notice (Please read before signing)

By swiping your credit card and signing this authorization, you authorize Patient First to charge your credit card for any and all unpaid amounts that Patient First or your insurer determines are your responsibility for items and services provided by Patient First. You agree that Patient First may charge your credit card for such amounts at the end of your current visit or at a later date.

After today's date, Patient First will notify you before charging any amount in excess of \$25.00 to your credit card. Notice will be provided via U.S. mail unless you authorize electronic notice by completing the reverse side of this agreement. Please be sure that your contact information on file with Patient First is correct.

A copy of this authorization is available upon request. You may revoke this authorization by writing to Patient First, Patient Accounts Department, 5000 Cox Road, Glen Allen, Virginia 23060. Revocation is effective five (5) business days after receipt.

Agreement

I, the undersigned, am an authorized user of the credit card that I swiped today. I hereby authorize Patient First to charge my credit card for balances due for items and services provided by Patient First. I agree to pay all amounts charged pursuant to this authorization in accordance with the issuing bank cardholder agreement.

Authorized User Signature

Printed Name

Date

Patient First[®]

Authorization for Electronic Communications

By signing below, you authorize Patient First to:

1. Use unencrypted electronic mail and/or text messaging to notify you of upcoming charges to your credit card; and
2. Provide your contact information and the contents of notices described above to any third party used to deliver email or text communications to you.

Your signature indicates that you understand that:

- A. Patient First will never include test results or other medical information in unencrypted email or text messaging.
- B. You may stop delivery of email or text messages at any time by following instructions contained in Patient First's communications.
- C. Email and text notifications will include your name, telephone number, email address, date of service, balance, and last four digits of your credit card number.
- D. The Internet is not secure and unencrypted email or text messages may be accessed or altered by unauthorized third parties. You agree to provide Patient First with prompt notice of any change in your email address or phone number used for text messaging. By signing this authorization, you accept the risk that a third party may be able to access or modify your information.

You further understand that:

- This authorization will be valid for all visits to Patient First until you revoke it or for any shorter period provided by law. You may request and receive a copy of this authorization.
- You may revoke this authorization of electronic communications by sending a written request to 5000 Cox Road, Glen Allen, Virginia 23060, Attn: Privacy Officer.
- If the contact information that you have provided is not accurate, information disclosed pursuant to this authorization may be re-disclosed and may not be protected by law.
- Your right to receive medical services will not be affected if you refuse to sign this authorization.

Signature of Patient / Guardian /
Personal Representative

Printed Name

Date