9360 Falls of Neuse Rd, Suite 105
Raleigh, NC 27615-2485

Tel:984-301-6494
www.knowandshowsolutions.com

KNOW AND SHOW SOLUTIONS, PLLC

Credit Card Authorization Form

It is worry free. Your payment is always on time (even if you are out of town), eliminating late charges and the possibility of collection agency reporting.

You authorize Know and Show Solutions to charge your credit card through Stripe via Simple Practice for the balance owed by you for your visits after the claims have been created (at the time of service for self-pay patients) or processed through your insurance provider as well as any administrative fees accrued. These charges will appear on your financial/credit card statement as, Know and Show Solutions. The signature below will authorize Know and Show Solutions to charge your credit card for any fees not collected at the time of service or not covered by insurance and/or deductible, co-pay, and co-insurance portions of your medical services provided. This authorization is an agreement that your credit card can be charged for any session that is not canceled at least 24 hours to the scheduled sessions (reference financial policies). A receipt for the charge will be sent through the web portal account.

1. The authorization you are signing will be valid for up to one year from date of submittal or until you cancel the authorization or if the card on file expires within the year.
2. All patients will require a separate form to be filled out.
3. Your credit card will **only be charged after 30 days** from the initial statement portal message alerting you of your balance with us.
4. Your credit card **will not be charged if payment is made within 30 days** from the initial electronic statement notification.
5. If the patient's insurance coverage is backdated to cover services previously denied, a refund will be processed for any patient credit once the remittance has been received (there is no refund for administrative fees).

For the safety of your credit card information, Know and Show Solutions secures and holds restricted access for all credit card information provided. The authorization is processed through a secured, encrypted channel and could be linked to Protected Health Information.

I hereby authorize **Know and Show Solutions** to charge the indicated credit card for the cost of medical services received at/from Know and Show Solutions. If I have insurance that Know and Show Solutions is in-network with, I authorize Know and Show Solutions to charge my credit card for deductible, co-pay, and co-insurance amounts as described above as well as any non-covered charges by my insurance provider. I certify that I am an authorized user of this credit card and will not dispute any charges with my credit card company without first making a good faith effort to remedy the situation directly with Know and Show Solutions, and as so long as the transaction corresponds to the terms indicated in this authorization form. I understand that my information will be saved to file for future transactions on my account for one year.

_____	_____	_____
Print Name of PATIENT	**Signed**	**Date**

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Credit Card Information ***(Debit Cards are strongly discouraged)***
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Patient Full Name _____ Patient Date of Birth ___ /___ /____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV_____
Cardholder ZIP Code (from credit card billing address): _____
Contact Phone: _____ Email: _____