ENHANCED WELLNESS OF OAK GROVE PLLC (EWOG)- 56 98 PLACE BLVD, HATTIESBURG, MS 39402 • (601) 264-7286

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.
If paid in full (Self Pay) by the patient on the Date of Service then a **PIF Discount** is applied.

Patient Name: _____

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Card Security Code: _____

Cardholder ZIP Code (from credit card billing address): _____

Services: ☐ Telehealth Visit ☐ Telehealth Visit ☐ Other _____

The patient acknowledges that the services listed above may not be covered by insurance, and they will have to pay at the time of service. EWOG will bill the patient's insurance for an official decision. I, **(Patient Name listed above)** , understand that if my insurance doesn't pay, I am responsible for payment I understand that I can appeal to my insurance company. Refunds will be made accordingly if insurance pays toward services. I, **(Patient Name listed above)** and/or **(cardholder)**, authorize **Enhanced Wellness of Oak Grove PLLC (EWOG)** to charge my credit card above for agreed upon services. I understand that this information will be saved to file in our HIPAA compliant software for future transactions on my account. I understand I can terminate this agreement at any time by providing written notice. I understand I need to provide at least 2 business days advance notice for termination.

- *Estimated Price is for the specified services only.*
- *Any additional labs/services/procedures are not included.*
- *PIF Discount of estimated price applies only if PAID IN FULL on/or before the date of the appointment.*
- *Failure to pay in full on the same day will result in having to pay the charges at **[100%]** without a discount.*

EXAMPLES:
Estimate: Telehealth/Office Visit Fee Schedule:

- 99213/G2211: **$399.00** (Level 3)
- 99214/G2211: **$521.00** (Level 4)
- 99215/G2211: **$690.00** (Level 5)

* Example: Price is **$260.50** (Level4 Visit 99214/G2211) [Fee: $521.00 Discount (-$260.50)]

Feel free to request a Patient specific estimate for the exact service/procedure/labs.

➔ _____ _____
Customer Signature **Date**

Return to EWOG via SMS text (**601-450-0953**); Fax (**601-450-4640**); or upload at our website: https://www.enhancedwellnessog.com/help/reference