Card On File Agreement

This Card on File Agreement (the "Agreement") is between Samantha Cohen, MD, Inc. (the "Practice"), and the undersigned patient or authorized individual acting on behalf of the patient (the "Patient").

1. **Purpose**: The Practice operates on a cash-based direct care model, which requires payment at the time services are rendered. The Practice requests that Patients maintain their credit or debit card on file to facilitate this process in a seamless and convenient manner. The Practice uses AthenaHealth as its Electronic Medical Record (EMR) system, and Elavon, Inc., a secure credit card processor affiliated with U.S. Bank. All credit/debit card transactions are processed through our service provider Elavon, Inc. This card on file agreement will be in effect for 12 months at a time. To continue the agreement after 12 months a new form needs to be signed by the Patient.

2. **Authorization**: By signing this Agreement, the Patient authorizes the Practice to enter the Patient's credit or debit card information into the Patient's electronic medical record within AthenaHealth so that the card can be charged and processed by Elavon, Inc. for the cost of services rendered at the time of each visit. Our office does not store credit or debit card information. The card on file information is handled and stored in a secure, encrypted manner by AthenaHealth and Elavon, Inc. Only the last 4 digits of the card on file will be visible in AthenaHeath. The Patient understands that the card information will only be accessed by authorized personnel.

3. **Charges**: The Patient agrees that the Practice may charge the card on file for any costs associated with services rendered under the terms of this Agreement. The Practice will provide a receipt to the Patient via email detailing the amount charged. If the Patient disputes any charge, the Patient agrees to notify the Practice in writing within 30 days of receiving the receipt.

4. **Card Information**: The Patient agrees to provide the Practice with accurate, up-to-date credit or debit card information and to promptly notify the Practice of any changes to the card information.

5. **Termination**: The Patient may terminate this Agreement at any time by providing written notice to the Practice. The Practice may also terminate this Agreement at any time with notice to the Patient.

By signing below, I acknowledge that I (the Patient) read, understand, and agree to the terms of this Agreement.

_____	_____	_____	_____
Patient Name (Print)	Parent/Guardian Name (Print)	Cardholder Signature	Date

For the Practice: _____ _____
Authorized Signature Date

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Optimizing Developmental Outcomes While Embracing Neurodiversity

SAMANTHA COHEN MD, INC.

Payment Information

Merchant ID:	8042115074
Date/Time:	
Card type:	
Card number ending in:	
Cardholder name:	
Transaction type:	Authorization of payment
Approval code:	
Reference number:	
Patient ID:	
Agreement ID:	
Cardholder email:	

Cardholder Signature: _____ Date: _____

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