

**About Care GYN Associates, P.L.L.C.**

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**Credit Card Information Form and Agreement**

I, \_\_\_\_\_, agree to allow  
(print name clearly)

About Care GYN Associates, PLLC, to charge my credit card with any remaining balances as **soon** as my insurance company has notified them of my amount due as indicated by the insurance explanation of benefits (EOB) that is sent to About Care GYN Associates, PLLC and to me. If I should have any questions regarding my responsibility, I understand that I am to contact my insurance directly for clarification. I fully understand that my information will be kept securely in my chart, guarded with the same level of security as the rest of my privileged information. If I am unable to present a credit card, I agree to pay a “retainer” fee of \$500.00 (paid in cash) that will be held and used to pay any balance(s) owed to Dr. DeCosimo.

**Please select from the following: *Please note that ATM cards are not accepted.***

VISA

MasterCard

**Please complete the information for the card you selected:**

Account Number: \_\_\_\_\_

Security Pin: \_\_\_\_\_ (3 digit number located on the back, right hand corner of your card)

Expiration Date: \_\_\_\_\_

Name: : \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_