INSURANCE-RELATED PAYMENT SECURITY

Dear Patient,

As you know, there are charges for each of the medical care services that we will provide to you. As always, our office is pleased to work with your health benefit plan to coordinate your benefits, maximize the covered services you are entitled to, and minimize your financial and administrative burden.

It can take as long as three months for your plan to process our claims. Furthermore, when plans assign financial responsibility to patients for charges, many patients wait months to pay our invoices. Sadly, a significant number do not pay at all. This situation places an unreasonable and unfair burden on our practice and its employees. In addition, in recent years the number plans with high patient deductibles (or where patients have health savings accounts) have increased dramatically. That means that we have to expend significantly greater effort and expense to collect many balances, often for long times after we have rendered services.

As a result, it is our policy to maintain credit card charge authorizations such as this on file, in order to secure payment for insurance-related patient balances. This practice saves our patients the hassle of paying mailed invoices, and avoids the potential risk to our patients of collection agencies and credit bureaus. **You can feel secure sharing this information with us – it is our responsibility to treat your financial information with the same respect and privacy guidelines as your medical records.**

In providing your information below, you authorize payment by credit card for services in the absence of payment by your health benefit plan (including, but not limited to, co-payment, co-insurance, deductibles, invoice fees, and/or services deemed non-covered by your health plan, as well as claims that are not adjudicated by your plan within 90 days), for charges up to $300 per each date of service obtained by the patient named below. If your financial responsibility exceeds that amount, the first $300 will be charged to your card upon our receipt of your insurer's Explanation of Benefits (either via mail or electronically), and you will be billed for any remaining balance by mail. **That invoice shall be payable by you in full upon your receipt.** We will mail you a receipt after your charges are processed. Unpaid balances may be sent to our collection agency for further collection attempts, according to our business practices, which may include reporting to credit agencies, and which includes an additional fee.

Patients' financial responsibility for these charges is bound legally by obtaining our services as well as by utilizing their health care plan. Should you contest the credit card charges for any of these approved transactions and those charges are reversed, you will remain fully responsible for the charges, and your balance due may be immediately sent to our collection agency without any delay.

By signing below, you affirm that you have read, understand and consent to all these policies.

Thank you kindly for your assistance.

PLEASE PRINT CLEARLY

Patient's Name: _____

Name of CardHolder: _____ *Must match name as printed on card exactly.*

Circle Brand of Credit Card: Visa MasterCard Discover American Express

Card Number: _____ Expiration date: _____

Security Code: _____ *This is the 3-digit code on the back of Visa, MC & Discover, and 4-digit code on front of AMEX.*

Street Address & ZIP code of the billing address: _____

By signing below, I authorize payment on this credit card to _____ for up to $300.00 per date of service, as explained above.

Authorized Signature: _____ **Today's date:** _____

Please give your credit card to the receptionist so that we may photocopy it.