ALL PATIENTS MUST COMPLETE

Dear Patient:

As you know, your health benefits, including your responsibility for co-payments, deductibles, and co-insurance is a decision made by you or your employer and your health plan, NOT THIS OFFICE. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number if, for any reason, your health plan does not honor the claim we submit for the services provided to you or pay portion of the claim.

The purpose of us having a credit card on file is to try to eliminate overdue accounts. As result we can spend more time addressing your needs instead of collecting money. If your insurance has any extra coinsurance or deductable above and beyond the co-pay that you have paid at the time of visit, you will be contacted by phone and your credit card below will be automatically charged. If you decide to use a different credit card, you can notify the office staff when they call you.

If you have a high deductible health plan, leaving a credit card on file is MANDATORY.

Please be aware that any balance **under $500 will be automatically charged** to your credit card.

By signing this agreement, you authorize Dr. Simhaee's practice to charge your credit card if your insurance has determined that you have further responsibility for payment such as, additional co-payments, co-insurance, deductibles, and/or uncovered services.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Payment Method: ☐Visa ☐MasterCard ☐American Express ☐Discover ☐ Flexible Spending Account

Account Number: ____ - ____ - ____ - ____

Expiration Date: ____ - ____ - ____
Month Day Year

V-code: ____ (3 or 4 digit security code- usually on the reverse side of the card)

Credit Card Billing Address:

Card Member's Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Card Member's Signature: _____ Date: _____

If you do not wish to provide us with credit card information, **PLEASE BE AWARE THAT THERE IS A $20 SERVICE CHARGE WILL BE ADDED TO YOUR BILL for every attempt we make to bill you for any charges. The first invoice is not included.**

I, _____, **do not** wish to provide the office with credit card information. **I accept the additional $20 service charge** that will be added to my bill for every attempt made by the office to collect any extra charges.

Patient Signature _____ Date _____