CREDIT CARD AUTHORIZATION FOR OUTSTANDING BALANCES AGREEMENT

Reasons for our policy: Having health insurance is not a guarantee of payment or coverage for services. The reason for this may be that you have not met your insurance policy's deductible; your insurance policy has a co-payment provision; there has been a recent change to the co-payment amount you are personally responsible for; there is no coverage for the medical service(s) under your insurance policy; your insurer voids or retrospectively terminates any and all benefits under your insurance policy; or, there is a shift in payment responsibility from your insurer to you, the patient.

It has also been our experience that on numerous occasions, our medical practice has not been reimbursed for medical services and/or supplies rendered to the patient and/or insured. In order to continue to provide high quality medical services at a reasonable fee, we require your credit or debit card on file as a convenient and timely method of payment for the portion of services for which you are liable. This authorization will in no way compromise your ability to dispute a charge or question how your insurance company processed your claim.

For insurance patients: You will receive an Explanation of Benefits (EOB) from your insurance carrier which will state any balance that is attributed to your copay, co-insurance or deductible. Payments to your card are processed only after the claim has been filed, processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

For self pay patients: This credit card authorization will be utilized for any outstanding balances which were incurred due to services rendered, but not paid for in full at the time of service.

A statement will be mailed to your address on file. If your bill remains outstanding for more than 30 days, with no attempt to reconcile your account, your card can automatically be charged for the total amount due. Please contact the office within 15 days of any changes to your home address, email address or phone number to ensure timely receipt of correspondence. Additionally:

- If your balance is over $200 you will receive a courtesy call prior to charging the credit card
- Any declined transaction with a balance of 30 days past due will incur an additional late charge of $15 per month

Receipt of payment using the credit card on file (Please choose one):

- ☐ Email receipt: Provide email _____
- ☐ Mail receipt to address on file
- ☐ No receipt necessary. My credit/debit card statement is sufficient.

As always your copay will be due at time of visit with the form of payment you choose to present and if not paid at front desk, this credit card authorization allows us to charge your copay as well as any other patient responsibility portion.

I authorize Sheryl Clark M.D. to charge my: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Name on Card _____

Credit Card Number _____

Expiration Date _____/_____ CVV _____ Billing Zip code _____

Signature _____

Due to Dr. Clark's limited availability because of her scheduling practices, a non-refundable cancellation fee of $35 for medical visits or $65 for cosmetic visits will be charged to the patient's account if the office is not provided with a 48-hour notice of the need to cancel or reschedule your appointment.