Payment Authorization Form

PATIENT NAME: _____BIRTH DATE: _____ACCT. NO. _____

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of all charges for services I receive from this practice, including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay, a previous balance, or an additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. **All co-pays are due at the time of service. This practice may deny service for failure to pay a co-pay at my scheduled visit.**

4. It is my responsibility to provide my current address, telephone number, email address, insurance card(s) and referral, if required, at each visit.

5. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that my payment is due by the date shown on my statement. I also understand that failure to pay could result in my account being sent to an outside collection agency.

6. I understand that I have the *option* of maintaining my preferred payment method on file. I understand that by completing the below section and providing my Card or ACH information, my payment information will be maintained on file digitally for future use by the practice for patient balances due. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

   Optional: ☐ Keep my preferred payment method on file for future use

   _____
   Name as it Appears on Card/ACH Account

7. With my prior approval, I authorize the above practice and/or its designated pmt agent to apply charges to my payment card and/or ACH account, using my preferred payment method stored on file, for balances I owe to the practice. This could be for medical visits, procedures, amounts agreed as part of a payment plan, copayments, coinsurance, amounts not covered by insurance or fees (if applicable) charged by the practice for failure to keep an appointment or provide timely notice of appointment cancellation.

8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid my account being sent to an outside collection agency.

9. Transaction receipts will be provided to me in person if paying on site, mailed if requested, or will be emailed to me if I provide and maintain a valid email address.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

AUTHORIZED SIGNATURE_____DATE _____

Billing Address City State Zip Code