

**Integrative**

**Family Medicine**

**Sports Medicine**

**at Chelsea**

**Credit Card Authorization Policy**

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your healthcare needs.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles, and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your insurance plan provides. A co-payment is always due at the time of service.

Therefore, in providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your insurance plan (including, but not limited to, co-payments, co-insurance, deductibles, and/or non-covered services.)

Our office will be pleased to work with your insurance plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your insurance plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

We will charge your credit card in following instance only –

1. Appointment cancelation Fee $50 (Please read cancellation policy for details).
2. Patient balance left after insurance payment. We will do the following before charging your credit card on file – (a) will mail ***three paper statements*** to your home address on file (b) Will make ***three follow up phone calls*** on the phone numbers provided by you (c) will charge CC on file only if no response received to a & b

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**www.sportsmedchelsea.com www.integrativefamilymed.com**