**CREDIT CARD ON FILE POLICY**

To Our Patients:

We have implemented a credit card on file policy. You will be asked for credit card information at the time you check in. This information will be held securely as your insurance processes your claim and notifies us of the patient responsibility amount due to any applicable co-insurance or deductibles. At that time, any remaining balances due as the patient’s responsibility will be charged to your credit card. A copy of the credit card charge and a receipt will be mailed to you. You will already be aware of this charge amount because your insurance companies mail an Explanation of Benefits to the patient before they send payment to us.

This will be an advantage to you, since you will no longer have to write out and mail a check to us. This process will benefit everyone in helping to keep the cost of health care down. As a practice, we have struggled to find creative ways to keep our costs and fees down in an environment where the costs of healthcare continue to rise.

This in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment. You may continue to pay your co-pay due at the time of your visit or any outstanding balances via cash, check, or credit card.

This authorization will remain in effect until rescinded by the cardholder.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely,

Paul Bizzaro, D.C.

**I authorize Paul Bizzaro, D.C. to charge outstanding balances on my account and the accounts of members of my family listed below to the following credit card (please check and add expiration date):**

VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ DISCOVER \_\_\_\_\_\_\_\_\_ AMEX \_\_\_\_\_ Card Exp. Date: \_\_\_\_\_\_\_Sec. Code\_\_\_\_\_\_

CC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Patient Name If Different)

Family Members to Be Included: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_