Capital Area Physician Weight & Wellness Center

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CREDIT CARD ON FILE POLICY

At Capital Area Internal Medicine, we require keeping your credit card or debit card on file as a method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit/debit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurance company, and the insurance portion of the claim has been paid and posted to your account.

Outstanding Balances: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, Capital Area Internal Medicine will notify you via phone and/or mail. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit/debit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I authorize Capital Area Internal Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□ **Visa** □ **Mastercard** □ **Discover** □ **American Express**

Credit/Debit Card Number: _____

Expiration Date: _____/_____/_____ Billing Zip Code: _____ CSV: _____

Cardholder Name: _____

Signature: _____

I, the undersigned, authorize and request Capital Area Internal Medicine to charge my credit/debit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. I authorize Capital Area Internal Medicine to charge my credit/debit card in the amount of my co-pay, coinsurance and/or deductible. This authorization relates to all payments not covered by my insurance company for services provided to me by Capital Area Internal Medicine.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give 60-day notification to Capital Area Internal Medicine in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____/_____/_____ Patient Date of Birth: _____/_____/_____