Stonecrest Family Medicine

01-01-2018

CREDIT / HSA / DEBIT / CARE CREDIT ON FILE AUTHORIZATION

At Stonecrest Family Medicine, PLLC, we strongly encourage you to keep your Credit / HSA / Debit or CARE Credit card on file as a convenient method of payment for the portion of services that your insurance doesn't pay, but for which you are liable. Your card information is kept confidential and secure in an off-site portal, and payments to your card are processed only after the claim has been filed and processed by your insurance, and the insurance portion of the claim has paid and posted to the account. If an email address is provided, you will receive an emailed receipt with the date of service processed noted.

I (we), the undersigned, authorize and request Stonecrest Family Medicine to charge my Credit / HSA / Debit or CARE Credit card indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that I will not receive a statement from Stonecrest Family Medicine for balances, and it is the responsibility of my insurance company to send an EOB (Explanation of Benefits) as a statement. I understand that if payment method declines, Stonecrest will reach out to secure the balance and a new form will have to be filled out.

This authorization relates to all payments not covered by my insurance company for services provided to me by Stonecrest Family Medicine. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Stonecrest Family Medicine, PLLC in writing and the account must be in good standing.

***☐ *I decline to leave a card on file or enroll in Care Credit. I understand that a $10.00 Administration fee will be added on to each date of service that requires a paper statement.*

Patient Name (Print): _____ Date: _____

Patient Signature: _____

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

☐ **Visa** ☐ **Mastercard** ☐ **Discover** ☐**Care Credit**

Expiration Date _____ / _____

Credit Card Number _____

Cardholder Name _____

Billing Address _____

City _____ **State**_____ **Zip** _____

Phone #:_____ **Date of Birth:**_____

Email:_____ **Your receipt will be emailed.**

Family Members attached to this account:_____

Internal Use Only: Billing ID_____ Initials:_____
Alert Added to:_____