certified
ALLERGY & ASTHMA
consultants

CREDIT CARD ON FILE POLICY & AUTHORIZATION

At Certified Allergy & Asthma Consultants, we now offer a Credit Card on File program as a convenient method of paying for the portion of services you owe after your health plan pays its portion of your claim. **Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statements.** Your credit card information will be kept confidential and secure, and charges to your card are made only after your health plan makes its payment us. You have the option of selecting a date on which charges can be made to your card, and limiting the amount that can be charged. We will mail you a receipt for the amount charged.

I (we), the undersigned, authorize and request that Certified Allergy & Asthma Consultants charge my credit card for the balance due that my health plan identifies as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Certified Allergy & Asthma Consultants. My card will remain securely stored for future use by Certified Allergy & Asthma Consultants for payment of balances due from me. This authorization will remain in effect until revoked by me in writing.

Patient's account # _____ **Patient's name:** _____

☐ **Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.**

Charge my card on the following day of the month (or the nearest business day prior to the day selected)**:**

☐ 7th ☐ 14th ☐ 21st ☐ 28th (default, if none selected)

Charge limits: Balances exceeding $_____ ***(minimum $200)*** require verbal authorization from me. Charges under this amount require no further authorization.

Patient/Guardian signature _____ **Date** _____

Credit Card Information:

Card type: ☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Card # _____ **CVV** _____ **Exp. Date** (Mo/Year) ___ / ___
Reminder to Staff --Destroy number after entering to secure site — Req'd – 3 or 4 digits — Required

Is this a Flexible Spending/Health Savings card? ☐ Yes ☐ No

Name as shown on Card (print) _____

Card's Bill To Street Address _____

City _____ State_____ Zip _____ Contact phone: _____

For office use only:
Authorization received by: _____ **Office location:** _____