CREDIT CARD ON FILE POLICY

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. An "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. This practice may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.

6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.

8. I authorize Dr. Colleen Daniel and/or her designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

I authorize Dr. Colleen Daniel to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____

CVV2 (3 or 4 digit number on back of card) _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____

State_____ Zip _____

I (we), the undersigned, authorize and request Dr. Colleen Daniel to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Colleen Daniel. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Dr. Colleen Daniel in writing and the account must be in good standing.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____ / _____ / ___