CARD ON FILE PROGRAM

Changes in our health care system and insurance policies have forced us to change all aspects of how we provide services to our patients. We have implemented a Credit Card on File payment system to provide a convenient way to pay your bill. This will allow our office to deliver a simpler, faster and more efficient bill pay system. The advantage to you is that you no longer need to write out checks or send payments in the mail. This reduces paperwork and ultimately helps lower the cost of healthcare.

HOW IT WORKS

Patients with insurance sign a consent form annually for card on file services, provide a credit card at initial check in before office visit, which we scan into our system. The information is held securely on an encrypted site.

Once we receive your **Explanation of benefits (EOB),** it notifies us of any additional amount owed by you. This is the **Patient Responsibility.** At that time, we will notify you that the remaining balance owed will be charged to the credit card. At the patient's request a copy of the statement can be emailed or mailed. We will attempt to contact you out of courtesy to let you know the card is going to be processed. If we cannot reach you, we will charge the authorized card on file.

Storing your credit card on file with us will not compromise your ability to dispute charges or question your insurance company's determination of payment. We accept Visa, MasterCard, Discover, and American Express. Health Reimbursement cards may also be used as card on file as long as there is a current balance.

Patients without health insurance, or who choose to opt out of the card on file program, are required to pay for services and materials in full the day of service/order.

I acknowledge that:

- **I am opting in to the Credit Card on File Program**
- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or copayment that is due at the time of service.**
- **I have received a copy of Eyecare Professionals HIPAA policy.**

_____ _____

Signature of Patient or Legally Responsible Person | Name (Please print)

_____ _____

Relationship | Date