

## AFTEROURS URGENT CARE

### CREDIT CARD AUTHORIZATION REQUIREMENT

In an effort to reduce the costs and annoyance of repeated statements and collection calls for patient balances, we have implemented a PCI compliant credit/debit card on file solution to help our patients manage their financial responsibility. We request that every patient presenting with commercial insurance provide us with a credit card, personal debit card, or HSA debit card at the time of service. Nothing will be charged to your card until the Explanation of Benefits (EOB) returns from your insurance company and we can confirm that all charges have been processed correctly and we have an accurate amount owed by the responsible party. The only amount charged to you will be the PATIENT RESPONSIBILITY portion as defined on the EOB as deductible, co-payment, and/or co-insurance. You will receive an email notification 7 days prior to the charge. If you receive an EOB from your insurance and disagree with the patient responsibility portion, kindly contact them to dispute and obtain a call reference#. Then contact our office at (888) 541-3432 to give us this information. We will confirm such with your insurance and reach out to you directly if we are unable to place a hold on the charge.

This system is that same as that found in many hotels, rental car companies and any place where orders are accepted online. We do not store your credit card information, rather we receive an encrypted token that is serves as authorization for payment by your bank and is specific to the date and services provided on that date.

#### **Authorization to charge my credit card, debit card or HSA debit card**

I authorize AfterOurs Urgent Care to charge my credit card, debit card or HSA debit card account for only the PATIENT RESPONSIBILITY portion listed on the Explanation of Benefits (EOB) up to but not exceeding \$400.00 (four hundred dollars). The PATIENT RESPONSIBILITY portion only applies to balances indicated as DEDUCTIBLE, CO-INSURANCE, and/or CO-PAYMENT amounts. If I feel the PATIENT RESPONSIBILITY portion listed on the Explanation of Benefits is inaccurate, I must resolve this directly with my insurance company. Any change in the Explanation of Benefits by the insurance company will be reflected as a credit or additional charge to the account on file.

\*\*If Insurance denies payment stating medical coverage was not in effect at the time of service, we will discount the bill to our SelfPay Program rates and process the card on file for such amount.

Patient/Responsible Party Printed Name\_\_\_\_\_

Signature\_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth\_\_\_\_\_

Patient Email: \_\_\_\_\_