PRIORITY CARE CLINICS, LLC

Credit Card Authorization for Outstanding Balances

We respectfully request that you please take a moment and review our policy for credit card authorization for any outstanding balances determined by your health plan to be your responsibility and the reasons for this policy. Please note that the **Credit Card Authorization for Outstanding Balances** agreement is meant to supplement and be consistent with **the General Patient Agreement.**

Our policy: It is our policy to request every patient or parent/legal guardian to provide us with a credit card or debit card authorization for any outstanding balances for services rendered and determined to be the responsibility of the patient or parent/legal guardian. We will put a $35 authorization hold on your credit card at the time of your visit. You will receive an explanation of benefits (EOB) via email or mail from your insurance company outlining what services were covered and how much remains as patient responsibility. We will also receive a copy of the EOB and will charge your credit card on file the amount due as indicated within 5-7 days of receipt of the EOB. If there is no balance due, your card will not be charged. A copy of the credit card receipt will be emailed or mailed to you. If your credit card is declined, we will call you to let you know. If we receive no response to a declined payment, a $35 declined payment fee will be applied. If you do not respond within 10 days, your account will be sent to collections with Pioneer Capital Solutions, Inc.

The aforementioned policy of requesting every patient or parent/legal guardian to provide us with a credit card authorization does not apply to patients with health coverage provided by Medicaid, Worker's Compensation, or self-pay patients who pay for services at the time of the visit.

In the event you refuse to have a credit card placed on file and authorize Priority Care Clinics, LLC, to charge that credit card for any and all amounts not covered by the patient's insurer and/or you have an outstanding balance, WE MAY REFUSE TO TREAT AND/OR PROVIDE YOU WITH MEDICAL CARE, (as we are a privately established business), unless such refusal is otherwise prohibited by State and/or Federal law and/or the provisions set forth in any applicable insurance policy and/or contract.

Acknowledgement of Payment Responsibility & Authorization to charge credit card:

I hereby understand that the **Credit Card Authorization for Outstanding Balances** agreement is meant to supplement and be consistent with the **New Patient Agreement** that I entered into with Priority Care Clinics, LLC.

I hereby state that I am personally responsible for the payment of my own and/or my dependent's medical care. I hereby willingly authorize Priority Care Clinics, LLC, to charge my credit card for any and all medical services rendered to me and/or my dependent/child that are not covered by my own and/or my child/dependent's health insurance policy. I hereby willingly provide my credit card information to Priority Care Clinics, LLC as set forth below.

I understand that I am personally responsible for the payment of treatment, medical services, and medical supplies including vaccines provided to me and/or my child/dependent by Priority Care Clinics, LLC.

I further understand that the payments for which I may be personally responsible include, but are not limited to, co-payment(s), deductible(s), co-insurance, and/or any outstanding balances or fees that are not covered by my own and/or my child/dependent's health insurance policy.

I, _____, hereby willingly authorize Priority Care Clinics, LLC, to charge my credit card for the balance of charges not paid by my insurer. I understand that generally I will be notified via email or regular mail as to the amount charged on my credit card to allow me to check my credit card statement to be sure that it is right. _____ (Initial)

I hereby willingly authorize Priority Care Clinics, LLC, to place a $35 authorization only hold on my credit card. _____ (Initial)

I am aware that, if my insurer pays Priority Care Clinics, LLC, after my credit card has been charged, I will be promptly reimbursed any credit due. In the alternative, if I so desire, I can request that Priority Care Clinics, LLC, retain all or some part of that amount as a credit on my account for my next visit. If I have any questions, I can contact Priority Care Clinics, LLC, at billing@prioritycareclinics.com

I affirm that the statements contained herein are true to the best of my knowledge; that I authorize to incur this charge to my credit card, and I thereby authorize future credit card charges necessary to pay outstanding balance as stated above.

Print Patient's Name _____

Signature of Patient / Legal Guardian: _____ **Date** _____