Credit Card Authorization Form

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel, rented a car or subscribed to NetFlix, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due.
At the time of services, we will request your credit card information and your consent to keep your credit card number on file for any copay or residual after insurance payment. Your credit card numbers will be encrypted and stored securely off-site. No credit card numbers will be stored at our practice.
Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via mail/text

Please note that all your rights with respect to the use of your credit card will remain in effect. This policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.
When will my card be charged?

We will submit your claim to your health insurance company if applicable. Once your insurance company processes your claim, you will have 30 days upon receipt of your billing statement to pay the amount due in any manner you wish. If you do not pay the amount due within 31 days, your credit card will be charged the Balance Due.

We ask that you complete the Credit Card Authorization Form. This agreement will apply to all family members under your account. Once we have entered your credit card information into our financial institution's encrypted system, the credit card information will be destroyed. Our staff will only be able to see the last 4 digits. You can also deliver your credit card information over the phone or by mail.

Consent

I hereby authorize my designated credit card to be kept on file in a secure and encrypted manner. The dental practice is authorized to charge up to $_____(please specify amount) on this card for copay amounts or residual balance after insurance payment.

I am consenting to use of this card for a one-year period, beginning on the date that I have signed this document.

_____

Signature

_____ _____

Printed Name Date