RELEASE OF MEDICAL INFORMATION AND PAYMENT FOR SERVICES NOT REIMBURSED BY INSURANCE

Name (please print): _____agrees to:

the charging to the credit card, health savings account, or debit card listed below, for copays, equipment, medications purchased directly from the practice, and/or medical services and equipment charges not covered or non-reimbursed by insurance. This will be done only after submission of claims to all relevant insurers, or after 60 days of non-payment. A receipt will be emailed to the patient.

Sign: _____

Date: _____

Credit Card/Debit Card Type: (circle one) Mastercard Visa Other _____(name)

Name on card: _____

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Security Code: __ __ __

Expiration Date: __ __ / __ __

Zip Code: ___ ___ ___ ___ ___

Email address: _____

This card can be used for non-basic lab work, equipment, medications purchased directly from the practice, and/or charges not covered by insurance. Patient balances that remain unpaid 30 days after our first bill is emailed to you, will be charged directly to your credit card. We will notify you of the payment due amount prior to charging your credit card.