2024 Credit Card Authorization Form
for The Asthma Center / Allergic Disease Associates, PC (the "Practice")

To all our Patients:

We have implemented a policy requiring patients to keep a debit/credit card on file at our office to make billing more convenient and efficient for our patients and staff. We will submit a bill for our services to your insurance company if you have insurance coverage. If a portion of the bill applies to the patient's responsibility, you will receive a statement from the Practice with the amount due, and likely will also receive an Explanation of Benefits (EOB) from your insurance company. If this amount due is not paid within 30 days, your credit card will be used to secure that portion. **I, acknowledge and agree that:**

- I am ultimately responsible for payment of all charges for services I receive from the Practice and acknowledge that co-pays, co-insurance, and any deductibles are due at the time of service. The Practice may deny service for failure to pay a co-pay or any outstanding balance at the time of service. Charges that do not successfully process or are denied through your credit card will remain your financial responsibility. ***Any charge that has not been paid within 30 days from your billing statement, will incur a late charge of $50.00.***
- I authorize the Practice and/or its designated payment agent to apply charges to my payment card for all amounts owed to the Practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) co-insurance, (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the Practice for failure to keep a scheduled appointment or provide timely notice of appointment cancelation.
- I will be provided a statement from the Practice for amounts due. If this amount due is not paid within 30 days, my credit card will be charged for the amount due. I will not be provided with additional notice of payments authorized hereunder beyond the Practice's billing statement. Transaction receipts will be maintained in the patient file or will be emailed to me at the email address provided below. I authorize the Practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the Practice in writing of any changes in my payment or other information.

I, the undersigned, authorize and request that the Practice charge my credit card for any outstanding balances when due. This authorization relates to all charges not covered by my insurance company for services provided to me, and fees charged, by the Practice. My card and payment information will remain securely stored for future use by Instamed, a third-party secure credit card processor that administers the billing and collection process of the Practice. This authorization will remain in effect until revoked by me in writing. I declare under penalty of perjury under the laws of the United States of America that my identity, signature and the foregoing is true and correct.

_____ _____

Cardholder Name as it Appears on Card | Cardholder Email Address

_____

Cardholder Billing Address | City | State | Zip Code

_____ _____

Cell Phone Number | MRN

_____ _____

CARDHOLDER SIGNATURE | DATE