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

To all our Patients:

Pursuant to our Financial Policy agreement, it is our policy to require patients to keep a current debit/credit card securely on file with our payment processor. We will submit a bill for every office visit and await payment from the insurance carrier whose information you have given to us. Your insurance carrier provides you with an Explanation of Benefits (EOB) statement which explains how your insurance coverage is applied and how much, if any, it paid to us. In accordance with this adjudication, any or all charges not covered are determined to be the patient's responsibility. Therefore, your credit card will be used to secure the unpaid amount or balance. Please note, in the event you wish to dispute the carrier's benefit payments, you must follow the claim appeal or review process required by the terms of your plan or policy. If you prevail in the appeal or review process, we will credit or reimburse you for any additional payments we might receive from your insurance carrier.

I understand, acknowledge and agree to the following terms:

- I am responsible for payment of all charges for services I receive from the Practice. I acknowledge and agree that co-pays, co-insurance, and any deductibles mandated by the terms of any insurance policy I own, or by my relationship with any other party/payor I may be affiliated with, are my obligation and are due at the time of service. The Practice may deny services for my failure to pay a co-pay or any outstanding balance at the time of service. Charges that do not successfully process with my insurance carrier or are denied by my credit card company or bank, will remain my financial responsibility. ***Any charge I have not paid within 30 days from the last visit, will incur a late charge of $50.00***

- I authorize the Practice and/or its designated payment agent(s) 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 cancellation.
- **I will not be provided with advance notice of payments authorized by this signed Credit Card Authorization Form.** Transaction receipts will be maintained in the patient file or will be emailed to me at the email address provided below. I authorize the above practice and/or its designated provider(s) 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. I understand and agree that authorization for payment of services already rendered cannot be cancelled or refunded. I agree to notify the Practice in writing of any changes in my payment or other information. **I authorize the Practice to charge my credit card for all charges incurred for dependent patients even if I am not the guarantor or other responsible person for such charges under the applicable insurance policy or otherwise, and even if I did not accompany the patient to our office for treatment.**

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 by the Practice. My card and payment information will remain securely stored for future use by a third-party secure credit card processor that administers the billing and collection process of the Practice. In addition, I understand and agree to receiving information from the Practice via email. By this Authorization I acknowledge that there may be inherent risks associated with electronic communications, including potential delays, data loss, unauthorized access, and security breaches. Furthermore, I acknowledge and agree that it is my responsibility to secure my electronic communication systems to ensure the security of sensitive information sent to me.
I hereby waive any claims against Allergic Disease Associates, PC T/A The Asthma Center (the "Practice") for damages arising from those risks associated with electronic communication systems and agree to use the service at my own risk.

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.

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Cardholder Name as it Appears on Card | Cardholder Email Address

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Cardholder Billing Address | City | State | Zip Code

_____

Phone Number | MRN

_____

CARDHOLDER SIGNATURE | Date