SOUTHWEST PEDIATRICS

CREDIT CARD CONSENT FORM

We now use a Credit Card Merchant Service called Instamed, which gives us the ability to swipe your credit card, debit card, or health savings account card to accept payment in the office and have the number securely stored on a remote server with Instamed. The full credit card number is NOT visible to us and is NOT stored in our office.

We want to assure you that our software has been thoroughly vetted according to the strict data retention rules required by the merchant processing system. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date, and the last 4 digits of the card number.

We require your credit card information to be stored for future payment for some of the following reasons:

- Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:
  - Deductible has not been met for the current calendar year
  - Co-insurance may be applied to the charges
  - Service may be deemed as not a payable benefit for your plan.
  - Policy has terminated, or there is a gap in coverage.
  - Newborn has not been added to the policy and are not covered under parent's benefits.
- You may have a copayment for medical services.
- You wish to set up a payment plan for a large balance on account.

We will notify you of your balance with one statement sent by mail after receiving the explanation of benefits (EOB) from your insurance company clarifying the reason for the money outstanding on the account(s). Once notified, you will have 30 days to discuss any questions or concerns regarding your balance(s) with us, or take care of the balance(s) on your patient portal online.

If we do not hear back from you or you do not pay your balance within the 30 days, we will attempt to make one courtesy call with the phone numbers on file. If we are unable to contact you, we will automatically charge your card for the amount due on the account(s).

Our Billing department will send you a receipt of any charges that are made to your card.

AUTHORIZATION

By signing below, I authorize Southwest Pediatrics to keep a credit card on file for future payments and to charge all balances accrued on the patients listed below with the information saved. I further understand that if a payment is denied by the credit card on file, I will not be able to schedule any further appointments with Southwest Pediatrics until the balance has been paid in full and account may be sent to outside collection agency and my child(ren) may be discharged from the practice. I am aware that if any of my personal information has changed, I am responsible to notify Southwest Pediatrics of the change(s) to ensure they have the most current information to contact me or process payment accurately.

_____

Your Child(ren)'s name

_____

Guarantor Printed Name

_____ _____

Guarantor Signature Date

❑ I have reviewed and understand Southwest Pediatrics' Financial Policy and Notice of Privacy Act