PRIORITY CARE CLINICS, LLC

**Credit Card Authorization for outstanding balances**

Dear Patients, Parents and/or Legal Guardians:

We respectfully request that you please take a moment and review the policy for credit card authorization for any outstanding balances determined by the health plans to be your responsibility and the reasons for this policy. Please note that the **Credit Card Authorization for outstanding balances** agreement is meant to supplement and be consistent with **the General Patient Agreement.**

**Our policy**: It is our policy to request every patient, parent and/or legal guardian to provide us with a credit card authorization for any outstanding balances for services rendered and determined to the responsibility of the patient, parent and/or legal guardian. You will receive an explanation of benefits (EOB) in the mail by your insurance company outlining what services were covered and how much remains as patient responsibility. We will also receive a copy of your EOB and will charge your credit card on file with the amount due as indicated within 5-7 business days of receipt. If there is no balance due, your card will not be charged. A copy of the receipt will be emailed to you or you can request a printed receipt from any of the front desk staff. If your credit card is declined we will call you to let you know. If we receive no response within 5 business days a $35 declined payment fee will be applied and a warning letter sent. If not response within 10 days, your account will be send into debt collections with Pioneer Capital Solutions, Inc.

The aforementioned policy of requesting every patient, parent, and/or legal guardian to provide us with a credit card authorization does not apply to patients with health coverage provided by Medicaid, Worker’s Compensation, and self-pay patients who pay for services at the time of the visit; furthermore exceptions can be considered upon request, on a case by case basis, and as otherwise provided by State and Federal law including, but not limited to, emergency and urgent care.

In the event you refuse to have a credit card placed on file and authorize Priority Care Clinics, LLC to charge that credit card for any and all amounts not covered by the patient’s insurer, PLEASE BE ADVISED THAT IN THE EVENT THERE ARE OUTSTANDING BALANCES, WE MAY REFUSE TO TREAT AND/OR SEE YOU AND/OR PROVIDE YOU WITH MEDICAL CARE unless such refusal is otherwise prohibited by State and/or Federal law and/or the provisions set forth in any applicable insurance policy and/or contract.

**Acknowledgement of Payment Responsibility & Authorization to charge credit card:**

I hereby understand that the **Credit Card Authorization for outstanding balances** agreement is meant to supplement and be consistent with the **New Patient Agreement** that I entered into with Priority Care Clinics, LLC.

I hereby state that I am personally responsible for the payment of my own and/or my dependent’s medical care. I hereby willingly authorize Priority Care Clinics, LLC to charge my credit card for any and all medical services rendered to me and/or my dependent/child that are not covered by my own and/or my child/dependent’s health insurance policy. I hereby willingly provide my credit card information to Priority Care Clinics, LLC as set forth below.

I understand that I am personally responsible for the payment of treatment and/or medical services and/or medical supplies, including vaccines, provided to me and/or my child/dependent by Priority Care Clinics, LLC.

I further understand that the payments for which I may be personally responsible include, but are not limited to, co-payment(s), deductible(s) and/or any outstanding balances or fees that are not covered by my own and/or my child/dependent’s health insurance policy.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby willingly authorize Priority Care Clinics, LLC to charge my credit card for the balance of charges not paid by my insurer in the event there is an outstanding balance due after the claim submitted to my insurance company for reimbursement were reviewed and processed by my insurance company. I understand that generally I will be notified via electronic mail or regular mail as to the amount of the charge to allow me to check my credit card statement to be sure that it is right.

I am aware that if my insurer pays Priority Care Clinics, LLC after my credit card has been charged, my credit card will be promptly reimbursed in the amount paid by my insurance company; in the alternative, if I so desire, I can request that Priority Care Clinics, LLC retain all or some part of that amount, as a credit on my account for my next visit. If I have any questions, I can contact Priority Care Clinics, LLC at [billing@prioritycareclinics.com](mailto:billing@prioritycareclinics.com).

I affirm that the statements contained herein are true to the best of my knowledge; that I am authorized to incur this charge to my credit card and hereby authorize future credit card charges necessary; to pay outstanding balance as stated above.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient and/or Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**