PATIENT NAME _____

CREDIT CARD POLICY

In our efforts to improve patient service and office efficiency, it is DuPage Children's ENT & Allergy's policy to maintain a credit card on file for each patient. We will store your information securely in our EMR which is PCI compliant.

After your insurance processes your claim, you will receive a statement from our office. You will then have **two weeks** to review and pay your balance.

I understand if you do not hear from me within two weeks, it is assumed that I am in agreement with the balance and my credit card will be charged.

Initials_____

This does not compromise your ability to dispute a charge or question your insurance company's determination of payment. We recommend you contact your insurance company first with any insurance discrepancies.

CREDIT CARD TYPE: VISA MC DISCOVER AM EX

LAST 4 DIGITS OF CREDIT CARD: ____ ____ ____ ____

EXP. DATE_____ (PLEASE HAND YOUR CARD TO THE RECEPTIONIST)

THIS CARD IS ALSO APPROVED FOR OTHER PATIENT(s) BELOW:

NAME	RELATIONSHIP
1)	
2)	
3)	
4)	

CREDIT CARD TYPE: VISA MC DISCOVER AM EX

LAST 4 DIGITS OF CREDIT CARD: ____ ____ ____ ____

EXP. DATE_____ (PLEASE HAND YOUR CARD TO THE RECEPTIONIST)

THIS CARD IS ALSO APPROVED FOR OTHER PATIENT(s) BELOW:

NAME	RELATIONSHIP
1)	
2)	
3)	
4)	

I understand I am responsible for all remaining balances including: co-pays, co-insurance, deductibles, denials, and any non-covered service as deemed by my insurance or office policy. I authorize DuPage Children's ENT & Allergy to keep this information on file and charge my credit card for payment and refund purposes only.

_____ _____/_____/
_____

Signature of card holder **Date**