Credit Card/Debit Card Authorization Form

Purpose: This authorization grants THE LUXE MEDICAL CLINIC permission to balance bill the card on file for amounts determined by your insurance carrier to be your financial responsibility (e.g., co-payments, co-insurance, deductibles).

📝 Authorization Statement (Please Read Carefully)

THE LUXE MEDICAL CLINIC submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to **balance bill a major credit card or debit card** to cover amounts determined by your insurance to be your responsibility.

We will verify if your insurance plan has a deductible. If you have not met your deductible, **we will charge your credit card for the contracted/allowable rate for any procedures performed during the visit.** Based on the Explanation of Benefits (EOB) from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain **absolutely confidential** and **securely stored** into our credit card processing system. **THE LUXE MEDICAL CLINIC will not store any banking account data.**

I hereby authorize THE LUXE MEDICAL CLINIC to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

Section 1: Patient/Cardholder Information

Field	Details
Patient Full Name	_____
Date of Birth	_____
Cardholder Full Name (if different from Patient)	_____
Billing Street Address	_____
City, State, Zip Code	_____
Phone Number	_____
Email Address	_____

Section 2: Payment Details

Field	Details
Credit Card Type	☐ Visa ☐ Mastercard ☐ Amex ☐ Discover
Card Number	
Expiration Date (MM/YY)	_____ / _____
Security Code (CVV/CVC)	_____

Section 3: Agreement and Signature

By signing below, I acknowledge that I have read and understand the Authorization Statement above and give my permission to THE LUXE MEDICAL CLINIC to automatically charge my credit/debit card for patient financial responsibility amounts after my insurance carrier has processed the claim.

Cardholder Signature: _____

Cardholder Name: _____

Date: _____