CREDIT CARD POLICY & AUTHORIZATION FORM

Why do I need to do this?

Chicagoland Complete Healthcare requires keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

How will my card be charged?

Your credit card information is kept confidential and secure. If your balance on the account is not paid within 60 (sixty) days after your claim has been processed by your insurance policy and posted to your account as "patient responsibility" your credit card will be processed. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Cancellation/No-Show appointments will also be charged to your card on file. Payment in full for your estimated co-pays are due at the time of your visit.

Will Chicagoland Complete Healthcare still see me if I refuse to keep a credit card on file?

Yes, we will see you, however, please be aware that without this authorization, a billing fee of $25.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Payment Arrangements

If your account has an outstanding balance and you have a current formal payment arrangement on file, your credit card will be processed for the agreed upon amount on the first business day of the month.

I authorize Chicagoland Complete Healthcare to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ CVV Code _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Chicagoland Complete Healthcare to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Chicagoland Complete Healthcare. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Chicagoland Complete Healthcare in writing and the account must be in good standing.

Patient Name (Print): _____ Date: _____ / _____ / _____

Patient Signature: _____

☐ I decline to place a credit card on file and understand that I will be subject to the billing fee and outstanding balance charge as per above.

Patient Signature: _____