# Patient Balance Payment Agreement

Our practice is acutely aware of the ever-escalating health care costs and we are doing everything feasible to help lower costs through increased efficiency. Recent changes in health care benefits have resulted in larger patient co-pays. deductibles and co-insurance.

Our staff is happy to assist you in estimating the portion of our fees that may be your responsibility. However, we cannot guarantee that the information given to us by the insurance company constitutes guarantee of payment. Ultimately, it is the patient's responsibility to verify and understand his/her insurance coverage.

It is costly and inefficient to send patients a monthly statement. We request that you assist us and help to reduce billing costs by completing the credit card authorization below. By signing the authorization, you can be assured that your credit card information will be securely stared and charged only for those fees your insurance company does not pay. We honor all contractual obligations with insurance companies with which we participate. You will never be charged in excess of allowed amounts.

For those patients who prefer to pay their balance by check, a debit card. or another credit card once we know your balance, we will mail you one statement for the full amount due. Full payment will be due in 30 days. If payment is not received in 30 days, the credit card you have on file will be charged for the full amount due. Any balance that exceeds 90 days will be turned over for collection with the addition of a $35.00 processing fee.

We accept checks: If your check is returned for any reason. you expressly authorize the clinic of Diamond Headache Clinic & Purath Headache & Neurology, to debit your account for the amount of the check plus a processing fee of $30.00. The use of a check for payment is your acknowledgement and acceptance of this policy.

## Credit Card Authorization

I hereby authorize the clinic of Diamond Headache Clinic & Purath Headache & Neurology to charge my HSA/HRA, debit. or credit card for any balance for which I am legally responsible. including deductibles. co-pays, co-insurance and non-covered items.

*(Please sign and date this agreement, then present your credit card to the receptionist to scan)*

Patient Name: _____ Patient Date of Birth: _____

Card Holder's Name: _____ Card Number:_____

Expiration Date: _____ CVV:_____

Signature: _____

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