FOUR PEAKS NEUROLOGY CREDIT CARD ON FILE AGREEMENT

Starting 1/1/2016 **FPN** can maintain your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed ONLY after the claim has been filed and processed by your insurer, after all appeals have been exhausted and the insurance portion of the claim has paid and posted to the account.

I authorize Four Peaks Neurology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

___ Mastercard ___ Visa

Credit Card Number _____

3 Digit Sec. Code _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

PLEASE PRINT EXACTLY AS IT APPEARS ON YOUR CARD

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

I, the undersigned, authorize and request Four Peaks Neurology 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 Four Peaks Neurology.
This authorization will remain in effect until I cancel this authorization. To cancel authorization I must give a 60 day notification to Four Peaks Neurology in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____/_____/_____