CREDIT CARD ON FILE POLICY

At Gentle Primary Care we require 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. Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

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, and the insurance portion of the claim has paid and posted to the account.

I ________________________, authorize OZ Healthcare dba Gentle Primary Care 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 OZ Healthcare dba Gentle Primary Care 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 Gentle Primary Care.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Gentle Primary Care in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ____

Date: ____