NEUROLOGY CLINIC
VERITYMD
HOPE, HEAL, ADVANCE

CREDIT CARD ON FILE AGREEMENT

VerityMD Inc. | Neurology Clinic
Phone: (916) 500-4989 | **Fax:** (916) 244-3875
Website: www.veritymd.com
Address: 5841 Jameson Court, Suite 2, Carmichael, CA 95608

To streamline the billing process and reduce administrative burdens, **VerityMD Inc./Neurology Clinic** requires all patients to keep an active credit card on file for payment of any outstanding balances not covered by insurance.

How This Works

1. **Secure Storage:** Your credit card information will be securely stored using encrypted, **HIPAA-compliant** payment processing systems.
2. **When Your Card Will Be Charged:**
   - Patient responsibility amounts (e.g., copayments, deductibles, and coinsurance) are due at the time of service.
   - Any remaining balance after insurance processing will be charged **14 days after you receive your statement**.
   - Missed appointment or late cancellation fees, as per our financial policy, will be charged immediately.
3. **Notification and Billing:**
   - You will receive an explanation of benefits (EOB) from your insurance carrier outlining their payment and your financial responsibility.
   - A **statement** will be sent to you before any balance is charged.
   - If you have any questions about your bill, please contact our billing department within **14 days** of receiving your statement.
4. **Card Expiration & Updates:**
   - If your card expires or is declined, you agree to update your payment method promptly to avoid any service disruptions.
5. **Refunds & Disputes:**
   - If an overpayment occurs, a refund will be issued to the original payment method.

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- If you believe a charge was made in error, you must notify our office within **30 days** of the transaction.

Credit Card Authorization

I authorize **VerityMD Inc./Neurology Clinic** to charge my credit card for any outstanding balance due after my insurance has processed my claim. I understand that I will receive a statement prior to any charge and that I can dispute any discrepancies before the charge is processed.

Patient Name: _____
Cardholder Name: _____
Last Four Digits of Card: _____ (Full card details will be stored securely)
Billing Address: _____
City, State, Zip: _____
Phone: _____

By signing below, I agree to the terms of this **Credit Card on File Agreement** and authorize VerityMD Inc./Neurology Clinic to process payments in accordance with the policies outlined above.

Signature: _____
Date: _____