

#### **CREDIT CARD ON FILE AGREEMENT**

**VerityMD Inc. | Neurology Clinic** 

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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.
- of If you have any questions about your bill, please contact our billing department within 14 days of receiving your statement.

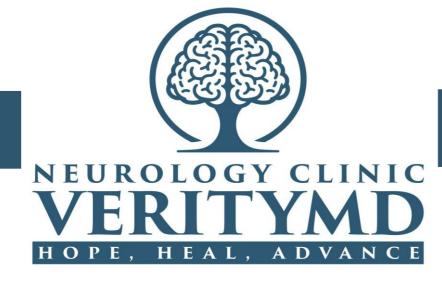
### 4. Card Expiration & Updates:

o 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.





。 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 <b>Credit Card on File Agreement</b> and authorize VerityMD Inc./Neurology Clinic to process payments in accordance with the policies outlined above.	
Signature:	
Date:	

