

Credit Card on File Agreement

Linda C Wang, MD, LLC has a credit card policy that enables you to maintain your credit card information securely on file, and to give us permission to automatically charge your credit card on file for any outstanding balance after insurance payments have been applied to your account. This agreement will remain in effect until the expiration of the credit card account. You may revoke this agreement at any time by submitting a written request.

Co-pays. I understand that my co-pay is due at the time of service and may be charged to the credit card on file if not paid during the visit.

Outstanding Balance After Insurance. We will submit all required claim information to your insurance plan (primary and secondary). Your insurance will process the claim and issue a final determination of benefits. Your insurance will pay their portion of the claim minus your co-pay, deductible, and co-insurance, which are your responsibility. After your insurance has completed processing, any balances that your insurance company should have paid but did not, including when secondary insurance does not pay, will also become your responsibility. Our system will automatically email or mail you a statement showing the remaining balance that is owed by you. We will charge your credit card on file for the outstanding amount. We will email a copy of the receipt to you. This in no way compromises your ability to dispute a charge or appeal your insurance company's determination of benefits.

Multiple Users. This card may be used for the credit card holder, their minor(s), and any patient(s) listed below.

I authorize Linda C Wang, MD, LLC to charge the above to the following credit card:

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Debit Card <input type="checkbox"/> HSA/FSA <input type="checkbox"/> Other _____
Card Holder's Name (as shown on card): _____
Last 4 digits of credit card: _____
Expiration Date: _____
ZIP Code (from billing address): _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient's Full Name: _____	DOB: _____
Patient's Full Name: _____	DOB: _____

Patient Signature: _____ Date: _____