Short Hills ophthalmology

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Credit Card on File Authorization Form

At Short Hills Ophthalmology, we require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance company doesn't cover, but for which you are liable. (PLEASE SEE CREDIT CARD ON FILE POLICY FOR FULL DETAILS.) **Initial**_____

Your credit card information is kept confidential and electronically secure at KEY BANK. Charges to your credit card are made only after the claim has been filed and processed by your insurer and the insurance portions of the claim has been paid, adjusted, and posted to your account.

I, the undersigned, authorize Short Hills Ophthalmology Group to charge the portion of my bill that is my financial responsibility as per the insurance company EOB to the following credit card. Balances $10 or less will be charged immediately, otherwise I will receive a statement from Short Hills Ophthalmology for the balance my ins company determines I owe. If you receive a "no-show" fee of $25 for not canceling or rescheduling your appointment without 24 hours notice, this charge will automatically be charged to your credit card on file. I understand that my credit card will be charged 30 days after statement date if other arrangements have not been made. I will receive a receipt via email only. I agree to notify and update my credit card as necessary. A $35 fee will be added to my account if my credit card declines. This authorization will remain in effect until I cancel it. To cancel, I must give a 60-day notification to Short Hills Ophthalmology in writing and the account must be in good standing. My card will be charged a $0.01 today to authorize the card and returned to me in cash.

☐ **Check here if you would like your card to be automatically charged for any balance on your account, without receiving a statement from our office. (Great for HSA/Flex Spending cards)**

If you are using Care Credit, please complete below:

___CareCredit FULL Card #_____ Expiration___/_____ CCV _____

Patient Name _____ Cardholder Name _____
E-mail Address _____
Signature_____ Date_____

If you are using any other Credit Card, please complete below:

___AMEX ___VISA ___MasterCard ___Discover

LAST 4 Digits Credit Card #_____ Expiration_____/_____ CCV_____
PATIENT Name_____ Cardholder Name _____

E-mail Address _____
Signature_____ Date_____