Bestcare
Internal Medicine

Authorization for Credit Card On File Payment

AUTHORIZATION

Until further notice, I authorize Bestcare Internal Medicinea, PLLC to charge the patient-responsible balances (co-pays, co-insurance, deductibles, non-covered services, elective items) on my account to the following credit card:

Circle one: Visa M/C Discover American Express

Last 4 digits of my credit card: ____ ____ ____ ____

Exp. Date (mm/yy):_____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance to be paid by me. I agree that **Bestcare Internal Medicine** may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $250.00, I will receive a courtesy call prior to my card being charged.

Signature:_____ Date: _____

Printed Name: _____

Email for receipts:_____