East Valley Diabetes & Endocrinology

Credit Card on File Authorization Agreement

Effective Date:

Patient Information

Patient Name: _____

Date of Birth: _____

Medical Record Number (MRN): _____

Credit Card on File Authorization

Thank you for choosing East Valley Diabetes & Endocrinology.

To simplify the payment process and help keep your account current, we ask our patients to maintain a valid credit or debit card securely stored on file.

Our payment system is designed to provide convenience while ensuring that insurance claims are processed before any applicable patient responsibility is collected for covered services.

By signing this agreement, you authorize East Valley Diabetes & Endocrinology to securely maintain your payment card information and process charges as described below.

How Your Card May Be Used

Your card on file may be used to pay your financial responsibility, including, when applicable:

- Copayments
- Deductibles
- Coinsurance
- Self-pay office visits
- Non-covered services you have agreed to receive
- Outstanding patient balances after insurance has processed your claim
- Returned fees (if applicable)

- No show Fee

New Patient: $100.00, Established patient $50.00 (Medicaid $25.00). Procedure/Imaging $100.00

- Late cancellation

Fee of $50.00. For Medicaid patients $25.00

Cancellations require a 24-hour notice.

Insurance will be billed first for covered services. Your account will be reviewed before any post-insurance charge is processed.

Charges Requiring Additional Contact

If your patient responsibility exceeds **$250.00**, our office will attempt to contact you before processing the charge unless you have previously agreed otherwise or immediate payment is required under another signed financial arrangement.

Medicare and Medicaid (AHCCCS) Patients

If you are covered by Medicare or AHCCCS (Arizona Medicaid), your card will only be charged for amounts that you are legally responsible to pay under applicable federal and state laws and payer regulations.

East Valley Diabetes & Endocrinology will not charge your card for amounts that are prohibited by Medicare, AHCCCS, or other applicable payer rules.

Security of Your Payment Information

Your payment information is securely maintained using encrypted payment technology. East Valley Diabetes & Endocrinology does not store complete credit card numbers in paper medical records.

Only authorized personnel may access payment information as necessary to perform their job responsibilities.

Patient Responsibilities

I agree to:

- Provide a valid payment card.
- Notify the practice if my card information changes.
- Review my insurance Explanation of Benefits (EOB) and contact my insurance carrier with any coverage questions.
- Notify the practice promptly if I believe a charge was processed in error.

Disputed Charges

If you believe a charge was processed incorrectly, please contact our Billing Department as soon as possible. We will review your account and promptly correct any verified billing errors.

Revocation of Authorization

You may revoke this authorization at any time by providing written notice to East Valley Diabetes & Endocrinology.

Revoking this authorization does not eliminate your responsibility for balances already owed or affect charges that were authorized before your revocation was received.

Authorization

I acknowledge that:

- I have read and understand this Credit Card on File Authorization Agreement.
- I have had the opportunity to ask questions.
- I authorize East Valley Diabetes & Endocrinology to securely maintain my payment card information.
- I authorize charges consistent with this agreement for my lawful financial responsibility.

This authorization will remain in effect until revoked in writing or replaced by a new authorization.

Patient Signature

Patient Name: _____

Signature: _____

Date: _____

If signed by someone other than the patient:

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ Other _____

Authorization Received By: _____

Date Received: _____

Entered into Secure Payment System By: _____