CREDIT CARD ON FILE POLICY

At **ClearInsight Psychiatry, Inc.,** we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. If your deductible charge is over $100.00 for the service after billing the insurance, we will notify you before we charge it onto your credit card. If the co-payments or deductible is under $100.00, we will charge it without notifying you.

Your credit card information is kept confidential and secure with Elavon/Converge, a strict HIPAA compliant website. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize **ClearInsight Psychiatry, Inc.** to charge the portion of my bill that is my financial responsibility to the following credit or debit card.
☐**Visa** ☐ **Mastercard**

I , the undersigned, authorize and request **ClearInsight Psychiatry, Inc.** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by **ClearInsight Psychiatry, Inc.**

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 90 day notification to **ClearInsight Psychiatry, Inc.** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____