Diane L. Ozog, M.D., S.C.

Credit Card on File Agreement

Diane L. Ozog, M.D., S.C. has implemented a new credit card policy. This is now standard practice in medical and other businesses such as hotels, car rental agencies, attorneys, etc. We now have a policy where we ask for a credit card on file which may be used later to pay any balance that is due on your bill. This information will be required to maintain a Patient-Provider relationship with our office. **Co-pays and fees for services are still due at the time of service.**

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, we will charge your credit card for any balance due after insurance has processed your claim(s) in accordance with our contractual obligation with them. Details of the charges can be provided upon request.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Diane L. Ozog, M.D., S.C. to keep my signature and my credit card information securely on-file in my account. I authorize Diane L. Ozog, M.D., S.C. to charge my credit card for any outstanding balances when due. I understand and agree that no prior notification will be provided before my credit card is charged.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Diane L. Ozog, M.D., S.C. a new, valid credit card which I will allow them to charge over the telephone. Even though Diane L. Ozog, M.D., S.C., is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Patient's Name (Print) : ____

Card Holders Name (Print): ____

Credit Card Number: ____

Expiration Date: ____/ ____ Security Code: __________

Email: _________________________________ DOB: _________________

Please authorize the use of this credit card for any other patients within the practice such as a spouse, or children etc. Please list them below.

Patient's Full Name (Print): ____________________________________ DOB: _______________

Patient's Full Name (Print): ____________________________________ DOB: _______________

Patient's Full Name (Print): ____________________________________ DOB: _______________

Please sign and date this document.

Name: ______________________________________ Date: __________________