Authorization for Claims Payment and Credit Card on File Agreement

Financial Responsibility

I understand if my Insurance Plan(s) does not consider this medical visit or any service rendered during this medical visit a covered service or has not authorized this service, they will not pay for this medical visit or services rendered during this medical visit. I agree to be fully responsible for payment to Agile Providers for this medical visit or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Agile Providers. I understand and agree this document will remain in effect for all future outpatient office visits to Agile Providers, unless specifically rescinded in writing by me.

Co-pays are due at time of the office visit. Payment is due in full at time of the office visit if not using health insurance.

Credit Card On File

We have implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving Agile Providers permission to automatically charge your credit card on file for your co-pay at time of service.
Outstanding Balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, Agile Providers will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Card Number	
Card Type: Visa, Amex, MC, Discover	
CVC (3 digit located on back of card. For Amex card, 4 digit in front of card).	
Expiration Date	
Billing Zip Code	

By signing below, I certify I have read and understand the foregoing, I have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In addition, I authorize this agreement will remain in effect until the expiration of the credit card account. I may revoke this form at any time by submitting a written request.

Patient Signature: _____ Date: _____

Patient Name: _____