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Credit Card Authorization for outstanding balances
(TO BE SUBMITTED BEFORE YOUR FIRST VISIT)

Dear Patients, Parents and/or Legal Guardians:

We respectfully request that you please take a moment and review the policy for credit card authorization for any outstanding balances determined by the health plans to be your responsibility and the reasons for this policy. Please note that the **Credit Card Authorization for outstanding balances** agreement is meant to supplement and be consistent with **the General Patient Agreement.**

Part I. Reasons for our policy: Having health insurance is not a guarantee of payment or coverage for services. The reason for this may be that you have not met your insurance policy's deductible; your insurance policy has a co-payment provision; there has been a recent change to the co-payment amount you are personally responsible for; there is no coverage for the medical service(s) under your insurance policy; your insurer voids or retrospectively terminates any and all benefits under your insurance policy; or, there is a shift in payment responsibility from your insurer to you, the patient.

As a result of the foregoing, it has been our experience, as well as the experience of many other doctors and/or medical practices, that this trend of requiring patients and/or responsible parties to pay for an increasingly larger portion of the treating doctor's bill will continue; this places a larger burden of financial responsibility on the insured/patient, the patient's guardian and/or the patient/insured's family. It has also been our experience that on numerous occasions, our medical practice has not been reimbursed for medical services and/or supplies (primarily vaccines) rendered to the patient and/or insured.

Example from another industry: If you come to a hotel to request a hotel room, at the check–in, you will be asked to provide a credit card for the night you spend in the hotel in the amount of the room per night as well as an authorization for any incidental charges the hotel may incur if you use their additional room service(s) such as food, beverages, internet, or whatever else may not be included in the hotel's initial price. For the most part, people readily agree, provide the hotel with their credit card number and authorize the establishment to charge his or her credit card for any incidental charges incurred during the stay.

Imagine that you would come to a hotel check in and tell the receptionist that you do not agree to be responsible for the hotel room charges? Do you think they would let you use their hotel services? If the hotels ran 10% losses on customer's who don't pay for their stay and/or services, they could go bankrupt. Medical practices can run the same risk and, have reacted to the uncertainty of reimbursement by no longer dealing with insurance companies and requiring patients to pay for services at the time of the service, requiring the patient himself/herself to seek reimbursement from the insurance company.

We would like to continue to be a practice that accepts insurance reimbursement, but we need patients/ parents to reimburse us the fees that are their responsibility, as indicated by your health plans, in a timely manner. The most efficient way to do this is to request that you authorize us to bill your credit card for any outstanding balances that your health insurer has determined to be your responsibility because of any one or more of the reasons set forth above.

Please rest assured that the information you provide us with is secure as we use a software service that provides a level of security similar or identical to the one used whenever you make a hotel reservation or book a flight online. Your credit card information is not stored in our systems, only your authorization. Your credit card information is encrypted and stored in a manner that is inaccessible to any of our staff or other party at Merchant Services of stripe.com with whom Bodhi Medical has an account with. Stripe is a nationally recognized merchant processing company that services numerous industries throughout the United States and abroad (https://stripe.com/gallery)

Part II. Our policy: It is our policy to request every patient, parent and/or legal guardian to provide us with a credit card authorization for any outstanding balances for services rendered and determined to be the responsibility of the patient, parent and/or legal guardian.

The aforementioned policy of requesting every patient, parent, and/or legal guardian to provide us with a credit card authorization does not apply to patients with health coverage provided by Medicaid, Medicare, Worker's Compensation, in-network patients with an insurance policy that provides otherwise, and self-pay patients who pay for services at the time of the visit; furthermore, exceptions can be considered upon request, on a case by case basis, and as otherwise provided by State and Federal law including, but not limited to, emergency and urgent care.

In the event you refuse to have a credit card placed on file and authorize Bodhi Medical Care, LLC and/or Apple Pediatrics to charge that credit card for any and all amounts not covered by the patient's insurer, PLEASE BE ADVISED THAT IN THE EVENT THERE ARE OUTSTANDING BALANCES, WE MAY REFUSE TREAT AND/OR SEE YOU AND/OR PROVIDE YOU WITH MEDICAL CARE unless such refusal is otherwise prohibited by State and/or Federal law and/or the provisions set forth in any applicable insurance policy and or contract.

If you are having a financial crisis, we would appreciate your discussing this with us prior to the service offered. Please email us at: yourdoctor@mybodhi.com and/or ask to speak with any staff.

Part III: Acknowledgment of Payment Responsibility & Authorization to Charge Credit Card: (example).

I hereby understand that the **Credit Card Authorization for outstanding balances** agreement is meant to supplement and be consistent with **the New Patient Agreement** that I entered into with Bodhi Medical Care, LLC and/or Apple Pediatrics.

I hereby state that I am personally responsible for the payment of my own and/or my dependent's medical care. I hereby willingly authorize Apple Pediatrics and/or Bodhi Medical Care, LLC to charge my credit card for any and all medical services rendered to me and/or my dependent/child that are not covered by my own and/or my child/dependent's health insurance policy. I hereby willingly provide my credit card information to Apple Pediatrics and/or Bodhi Medical Care, LLC as set forth below.

I understand that I am personally responsible for the payment of treatment and/or medical services and/or medical supplies, including vaccines, provided to me and/or my child/dependent by Apple Pediatrics and/or Bodhi Medical Care, LLC.

I further understand that the payments for which I may be personally responsible include, but are not limited to, co-payment(s), deductible(s) and/or any outstanding balances or fees that are not covered by my own and/or my child/dependent's health insurance policy.

I, _____ hereby willingly authorize Apple Pediatrics and/or Bodhi Medical Care, LLC to charge my credit card for the balance of charges not paid by my insurer in the event there is an outstanding balance due after the bills submitted to my insurance company for reimbursement were reviewed by my insurance company. I understand that generally I will be notified via electronic mail or regular mail as to the amount of the charge to allow me to check my credit card statement to be sure that it's right.

I am aware that if my insurer pays Apple Pediatrics and/or Bodhi Medical Care, LLC after my credit card has been charged, my credit card will be promptly reimbursed in the amount paid by my insurance company; in the alternative, if I so desire, I can request that Apple Pediatrics and/or Bodhi Medical Care retain all or some part of that amount, as a credit on my account for my next visit. If I have any questions, I can contact Apple Pediatrics and/or Bodhi Medical Care at yourdoctor@mybodhi.com.

I affirm that the statements contained herein are true to the best of my knowledge; that I am authorized to incur this charge to my credit card and hereby authorize future credit card charges necessary; to pay outstanding balance as stated above.

Patient Name: _____ Signature of Patient and/or Legal Guardian: _____

Date: _____

You will receive a copy of this credit card authorization via email and if you wish it can be also printed for you at our office.