Specialists In Reproductive Medicine & Surgery, P.A.

www.DreamABaby.com • Fertility@DreamABaby.com

Excellence, Experience & Ethics

Credit Card Information Form

To Our Patients:

In an effort to combat rising healthcare cost, we have recently implemented a policy where you will be asked for a credit card number at the time of check in. The information will be held securely until your insurance has paid its portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well since it will greatly decrease the number of statements that we have to generate and send out. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays will still be due at the time of the visit. If you have any questions about this policy, do not hesitate to ask us.

OFFICE USE ONLY:

PATIENT ACCOUNT#:_____ SPOUSE/PARTNERS ACCOUNT#:_____

Credit Card Information:

Please complete all fields below sign and date:

□ **Visa** □ **MasterCard** □ **Discover** Spouse/Partners Name:_____

Patient Name: _____ □ I also authorize charges to be paid

Credit card # _____ out for my spouse/partners account.

Expiration Date: _____ ___ **please initial your authorization**

Card Holder Name: _____

(please print clearly)

Address Card is Billed To:

_____

AUTHORIZATIONS AND PAYMENT AGREEMENT

When assignment is accepted, I hereby authorize payment to be made to Craig R. Sweet, M.D. and SRMS for benefits payable under the terms of my insurance or governmental coverage for any service I receive at Specialist in Reproductive Medicine & Surgery. I understand that I am responsible for any balance on my account not covered by my insurance company. I hereby authorize Craig R. Sweet, M.D. to charge my credit card with the portion of my responsibility after my insurance has reimbursed for services rendered. I further understand that, if I have provided a debit card and such charges to my bank account should result in an overdraft, I will hold harmless Dr. Sweet and his office personnel of any and all related fees that my bank would assess.

Print Name: _____

Patient Signature: _____

Card Holder Signature: _____ **Date:** _____

Updated: 08/26/2009

K:/Docs/Forms/Credit Card Information Form.doc