Newborns To Geriatrics
RIVERSIDE FAMILY HEALTH PL
Stephane Naoumoff, MD
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# CREDIT CARD ON FILE POLICY

We can now **SECURELY** keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. This authorization is intended as a courtesy to save you time, as well as saving us the time and expense of preparing and sending out statements to collect patient balances from services you have already received from Dr. Naoumoff. Furthermore, we now charge an "outstanding balance" charge of 1.5 percent of the total bill for each month that your bill remains unpaid and this will help you to avoid this additional finance charge from us.

**Your credit card information is kept confidential and secure** and 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 paid and posted to the account. ***Please choose one option below***

_____ *INITIAL*

I **decline** to sign up for this convenient service, and understand that I may be subject to additional finance charges for amounts owed by me, in accordance with our Office Payment Policies.

--OR –

_____ *INITIAL*

I authorize and request Riverside Family Health, PL to charge my credit card, indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility.

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ Cardholder Phone (_____)_____

Cardholder Name _____

Cardholder Signature _____

Billing Address _____

Maximum charge limitations: ☐No Limit ☐$50 per visit ☐$100 per visit ☐$_____

This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Naoumoff and Riverside Family Health, PL.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give written notice to Riverside Family Health and the account must be in good standing.

Patient Name (Print): _____ Date of Birth ____ /____ /_____

Patient Signature: _____ Effective Date____ /____ /_____