Patient Name_______________________________

1660 W Antelope Drive, Ste. 225,
Layton, UT 84041
P: 801.775.9800
F: 801.775.9806

Debit/Credit Card Authorization

Dear Patient,

Our staff works hard to coordinate with your insurance company to make sure that the amount we collect from your insurance and the amount owed by you for is accurate, according to your individual insurance plan.

Your insurance company will be billed for applicable charges for today's services. After payment has been received from your insurance company, we will charge your credit card for any remaining balance due on the 25th of the month. If your insurance company has not paid the claim within 90 days, we will charge your debit/credit card for the balance due. Should your insurance company subsequently make payment to our office we will refund your debit/credit card immediately. This policy in no way compromises your ability to dispute a charge or questions your insurance company's determination of payment.

It is our hope that this new policy will work to our mutual advantage since you will no longer have to send a check or give debit/credit card information over the telephone. This will greatly decrease the number of statements generated and mailed each month. Please note that your information will be stored in our secure accounting system.

As always, we strive to provide you with the highest level of care and look forward to continuing to do so.

Primary: Visa/Master/Discover/American Exp.

____
Card Number

____
Expiration Date 3-4 digit V-code

____
Cardholder Name (Exactly as Printed)

____
Billing Address for Card (Street, Apt.)

____
City, State, Zip

____
Cardholder's Signature Today's date

Alternate: Visa/Master/Discover/American Exp.

____
Card Number

____
Expiration Date 3-4 digit V-code

____
Cardholder Name (Exactly as Printed)

____
Billing Address for Card (Street, Apt.)

____
City, State, Zip

____
Cardholder's Signature Today's date

☐ I authorize Rocky Mountain Allergy, Asthma, and Immunology to charge my debit/credit card for the balance due on my account. Please select one of the following and sign below:

- ○ OK to run balance without contacting me.
- ○ Leave voicemail at (_____)_________________ before running card if balance exceeds _______ ($100 minimum).
- ○ Call (_____) _________________ for verbal approval if balance exceeds _______ ($100 minimum).

If no response within 48 hours, the balance will be charged to the card on file

☐ I decline the offer to put my credit card on file and understand I will be charged a $25 statement fee each month upon unpaid account balance as explained in the "Financial Policy".

____ Signature

_______________________ Today's Date