WILLIAM E. KIMBALL, O.D. VICTOR A. RICHARDSON, O.D. LIANN H. KIMBALL, O.D.

CREDIT CARD ON FILE POLICY

As you know, the medical landscape has become more and more burdensome to navigate, with greater cost sharing every year. In order to continue providing the kind of care our patients deserve, it has become necessary to require a credit card/HSA/FSA card be left on file to cover any balance due to deductibles, coinsurance, copays, lack of coverage or payment failure.

Your credit information is kept completely confidential and secure. Your balance will be billed to your card only AFTER your insurance company has processed your claim and paid their portion. We will call to notify you of the amount we will apply to your card.

I authorize Progressive Eye Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□Visa □Mastercard □Discover □HSA □FSA

Credit Card Number____

Expiration Date _____ / _____ / _____

Cardholder Name ____

I, the undersigned, authorize and request Progressive Eye Care to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization will remain in effect until I cancel this authorization. To cancel, I must provide notification to Progressive Eye Care in writing and the account must be in good standing.

Patient Name(Print):____

Patient Signature:____

Date:_____ / _____ / _____

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