



To Our Valued Patients:

Because of runaway medical costs, OB/GYN Centre of Excellence has implemented a new policy. You will be asked for a credit card number at the time you schedule surgery and the information will be held securely until your insurances have paid their 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. If you are unable to provide debit or credit card information, a deposit of \$500 or completing an application for automatic drafts from your bank account is needed.

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. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask us.

Thank you.

.....
Type of Card: *Credit Card* *Flex Spending* (*Automatically processed once insurance pays.*)

Debit Card (*Courtesy Call: Yes No. If yes, number to call _____.*)

Card Company: *American Express* *Discover* *Master Card* *Visa*

Credit Card Number: _____ - _____ - _____ - _____ *Expiration Date:* __/__/____ *V-Code:* ____

Name as it appears on the card: _____

Our office will automatically charge credit cards and flex spending accounts without a courtesy call. If elected, a courtesy call is available for debit cards only. If our office does not receive a response from the patient within 24 hours of the courtesy call, the debit card will be processed based on patient responsibility. I agree to the above-mentioned policy and authorize OB/GYN Centre of Excellence to bill my credit/debit card for payment due on surgical procedures I am scheduling.

Signature: _____ *Date:* _____

.....
Office use Only

Patient Name: _____ *Acct #:* _____ *Date of Surgery:* _____