SHELBY MEDICAL ASSOCIATES, P.A.
CREDIT CARD AUTHORIZATION FORM

At Shelby Medical Associates, our goal is to provide you with the best, most current medical care available in a positive and supportive environment. In order to do this, we must constantly strive to reduce and minimize our costs of doing business. Collection of patient payment responsibilities are critical to maintaining the quality of care you expect from Shelby Medical Associates.

In an effort make patient payments more cost effective for everybody, we are asking you to provide us with a credit card authorization. This approach is widely used by hotels, rental car agencies, gasoline stations, internet shopping sites, and mail order pharmacies.

Nothing will be charged to your credit card until the Explanation of Benefits (EOB) returns from your insurance company and we can accurately determine your patient payment balance. The only amounts charged to your credit card will be the PATIENT RESPONSIBILITY portion as defined by your insurance company's EOB, missed co-pays, returned checks, approved tests not covered by insurance, etc.

This information is confidential. This form will only be kept by Shelby Medical Associates Billing Department.

Please enter all information.

PATIENT NAME: ______________________________ ACCT #: ______________

PHONE # (xxx-xxx-xxxx): __________________ ALTERNATE #: __________________

NAME AS ON CREDIT CARD: ________________________________

CARD TYPE: ___ Visa ___ MasterCard EXPIRATION DATE (month /year): ____________

CREDIT CARD #: __________________________ THREE DIGIT CV CODE: ____________

CHECK ONE OR MORE AS APPLICABLE:

____ MONTHLY PAYMENT OF $ ____________ FOR _____ MONTHS

____ ONE-TIME CHARGE AMOUNT OF $______________

____ MONTHLY RECURRING ON BILLED CHARGES

As elected above, I authorize Shelby Medical Associates, PA to charge my credit card with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB), and any charge not paid for by insurance. I understand that I can dispute the charge at any time with my credit card company; however the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card.

AUTHORIZATION SIGNATURE: ________________________________

DATE: ______________