Sandia Neurology Credit Card on File Policy 2019

Patient Name _____ Date _____

Thank you for choosing Sandia Neurology for your neurological consultation and care. We are honored to help you understand your neurological issues and help develop a treatment plan for you. Please complete and return to front desk with your card. You are welcome to contact your insurance company to get an estimate prior to the visit. Typical new patient or consult codes used can be obtained by asking the front desk.

___ I understand that my insurance usually does not cover my entire bill for my upcoming visit.

____I agree to leave my credit card in secure file in Sandia Neurology to be run automatically in case of charges determined by my insurance company which are my responsibility to pay. When my card is run, I will receive in the mail during the next week and a paid invoice from this clinic.

____Instead of leaving a card on file, I prefer to pay up front the SELF PAY discounted rate amount for the entire visit (refundable after insurance pays) instead of leaving the card information on file. (Skip to signature on bottom.)

____If my card is lost, stolen, declined, or changed, I agree to inform Sandia Neurology immediately with a replacement. Any account with a declined card will be notified, then sent to third party assistance. Service fee may be added.

___ If I miss an appointment with less than a business day notification (Monday morning appointments must be cancelled by Thursday noon) to the clinic, I agree to have my card run for the amount of the No Show fee of $75 for a follow up or $150 for a procedure, injection, or EMG. (No show fees are not charged for medical emergencies.)

My signature on this form is the same as the one I use to sign my credit card receipts with and may be used instead of a signature on the receipt.

Call me ___ or Text me ___ card is run at _____OR run and mail receipt.____

Name on card: _____

Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Address for card billing: _____

_____

Expiration date ___ ___ / ___ ___ Security code on back of card ___ ___ ___

Phone number to reach me if there is a problem _____

Email for receipt _____

Signature _____ Date ___ ___/___ ___/___ ___ __ ___

Show card to Dr. Harris or staff members _____ _____