Marilyn M Jackson MD. MPH PLLC
421 West 57 St. suite B
NY, NY 10019

LETTER OF AUTHORIZATION TO CHARGE CREDIT CARD

We have implemented a policy requiring a credit card be held on file effective January 1, 2017. As with other industries, this has become standard practice in health care. As you may be aware, the current healthcare market has resulted in employers selecting health care insurance policies that have increasingly transferred cost to you, the insured. Most insurance plans require deductibles and co-payments not known to you or us at the time of your visit. As your physician, I want to continue providing you with excellent care, but in order to do so; it is necessary to ensure reimbursement for our services.

We want to assure you that we will bill your credit card in the following situations only:

1. You instruct us to bill your credit card for any outstanding balance
2. Your balance is 60 days past due and we have sent you statements
3. Your insurance card is invalid and you do not have another insurance

The following patients are exempt from having a credit card on file:

1. Patients that are self-pay will not be required to place a credit card on file. Payment in full is expected at the day of the visit
2. Patients with ACTIVE MEDICAID benefits will not be required to place a credit card on file
3. Patients with insurance willing to pay 100% of the visit at the time of services rendered will not be required to place a card on file.

I, ________________ ________________, authorize **Marilyn M. Jackson, MD, MPH PLLC** to charge the following described credit card the amount equal to what my insurance states is my responsibility.

___ I understand the amount shall not exceed the amount my insurance deems as my responsibility.

___ I understand I will be sent an email informing me of the date of my visit, and the amount to be charged to my credit card. A receipt will be sent upon request.

___ I understand that this Credit Card Authorization will only be used if my insurance does not pay for any services provided by **Marilyn M. Jackson, MD, MPH PLLC.** This may include, but is not limited to; Deductibles, Co-insurances, Co-pays, Policy cancellations and Services not covered under my policy, and no-show fees (not covered by insurance).

___ I understand that if my credit card is declined and/or does not process the payment, an invoice will be mailed to me with a $15 surcharge added to my balance.

Card Holder's Name on Card: ______________________________ Tel# _____________________

Card Holder's Address: ____

Credit Card Type: _____ Mastercard _____ Visa _____ American Express

Credit Card Number: ____

Exp. Date: _______________________

Security Code: __________________

Email Address: ________________________@_____________________

I fully understand the above authorization and give **Marilyn M. Jackson, MD, MPH PLLC** consent to charge my Credit card listed above.

Signature: ____

Printed Name:____ Date: ________________