



**Credit Card on File**

In our efforts to **Go Green** and become a paperless office, we have implemented the credit card on file. You may participate as a convenience. You will be asked for a credit card number at the time you check in. The information will be held securely until your insurance has paid their portion, and notified us of your financial responsibility. We will notify you by phone, email or mail prior to charging your account. At that time any remaining balance due to Designing Smiles will be charged to your credit card.

You will no longer have to take the time to prepare mail and respond to billing statements, write out checks, pay for postage and envelopes, etc. It will be an advantage to us, since it will greatly decrease the number of paper statements that we have to generate and post in the mail. This is a win-win for everyone by keeping the costs of health care down and by allowing us to concentrate first and foremost on your dental needs.

To alleviate any concerns that you may have, our computers are password protected, fire walled, HIPPA compliant, and secure. Your information will never be shared, all paper copies will be scanned into the computer. All personal information, including credit card information is securely embedded in a complicated dental software program, used for that purpose. Our office is also protected by an alarm system.

Our credit card on account policy in no way will compromise your ability to dispute a charge. We will email your statement, receipt, or a copy of your EOB (explanation of benefits). All co-pays and deductible amounts will be due at the time of your visit on the date of service, as usual.

**Credit Card on File**

Patient Name: \_\_\_\_\_ Family Member's Name \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_ [  ] Visa [  ] MasterC [  ] AmEx [  ] Discover [  ] CareCredit

Cardholder's Address: \_\_\_\_\_

Account #: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Security Code: \_\_\_\_\_

*By signing below, I authorize, Designing Smiles and its associates, to charge any remaining balances due on my account, or that of my family members listed above, and I agree to abide by the terms in this financial policy.*

**Signature** (Responsible Party) **X** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Billing Address (if different):** \_\_\_\_\_