NORTHEAST NEUROPSYCHOLOGY
BRAIN & BEHAVIORAL HEALTH PARTNERS

# Credit Card on File Policy

To Our Patients,

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or to us at the time of your visit. While we make every effort to estimate these costs for you, we do not always receive correct information from the insurance company.

You are being asked to sign our credit card authorization form so that we can collect patient balances in a timely manner. **You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed using the credit card on file.** ***You will receive a courtesy call from us just prior to charging your card if there are any balances over $150.***

Your credit card information is guarded with the same care and security as your medical information. Our system separates your card number in two separate, HIPAA compliant practice management systems so that no one system has all of your card number.

Signing this form in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment policy, do not hesitate to ask.

By signing below, I authorize Northeast Neuropsychology to keep my signature and my credit card information securely on-file in my account. I authorize Northeast Neuropsychology to charge my credit card for any outstanding balances due. This could be amounts resulting from balances related to copayments, deductibles, co-insurances, non-covered services or denials for no coverage/eligibility but is not limited to these scenarios.

**Patients with verified active Medicaid or Workers' Compensation coverage are exempt from filling this out.**

____ Visa ___Mastercard ___Discover ___Amex _____Other (specify)

Patient's Name:_____

Name on Card:_____ Relationship:_____

Card Number:_____

Exp. Date:_____ CVV Number:_____

Cardholder Signature: _____ Date:_____/____/_____

**Cheshire Office:** 609 West Johnson Ave, Suite 104 • Cheshire, CT 06410
**Farmington Office:** 231 Farmington Avenue • Farmington, CT 06032
**Phone**: (203) 272-6007 • **Fax**: (203) 272-8895 • www.NENEUROPSYCH.com