CALL DOCTOR PACKER TELEMEDICINE

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Credit Card on File Authorization & Patient Financial Responsibility Agreement

To make billing more convenient, reduce unexpected outstanding balances, and clearly explain our payment procedures in advance, **Call Doctor Packer Telemedicine (CDPT)** maintains the following Credit Card on File and Patient Financial Responsibility Policy.

Secure Payment Information

Your payment-card information will be maintained through our authorized electronic payment-processing system. The practice will not place your complete credit-card number in your medical chart, ordinary email, text message, or routine administrative documentation.

Practice staff should **never ask you to send your complete credit-card number, expiration date, or security code directly in an ordinary email or text message**.

Instead, when payment information is required, you may receive an **email or text message containing a secure payment link through our authorized payment-processing system**. You may click the link and enter your payment-card information directly into the payment system.

The purpose of this process is to allow you to provide payment information directly through the authorized payment platform rather than sending your complete card information to practice staff through ordinary email or text messaging.

Charges at the Time of Scheduling or Service

For insured patients, applicable copayments and other patient-responsibility amounts that are known and properly due at the time of scheduling or service may be collected in accordance with your insurance benefits, applicable payer requirements, and the practice's financial policy.

For appointments scheduled **less than two weeks in advance**, all applicable amounts that can be appropriately determined before the appointment - including copayments, coinsurance, deductibles, and other applicable patient responsibility - must be addressed before the appointment is finalized, subject to the requirements of your health plan and applicable law.

For self-pay patients, **50% of the applicable self-pay fee will be collected before the appointment**.

The **remaining 50% of the self-pay fee will be due 30 days later**. You will receive at least **seven (7) days' advance notice** before the practice initiates the card-on-file charge for that remaining balance.

Current Initial Self-Pay Rates

Telemedicine initial telemedicine visit: $100
Initial in-person visit: $149

The applicable self-pay rate will be explained before the appointment is finalized.

Charges After Insurance Processing

After your insurance company processes your claim, you may remain responsible for amounts properly determined to be your responsibility under your health plan and applicable law, including applicable:

- Copayments
- Coinsurance
- Deductibles
- Patient-responsibility amounts
- Non-covered services for which you are legally and contractually responsible

Before your card on file is charged for a **new balance identified after insurance processing**, the practice will provide you with at least **seven (7) days' advance notice** of the intended charge.

The notice will identify the amount to be charged and will provide you with an opportunity to contact the practice if you believe the amount is incorrect or if you wish to discuss an available payment arrangement.

Insurance payments and patient responsibility remain subject to your applicable health plan, payer contract requirements, and federal and state law.

Nothing in this authorization permits the practice to collect an amount that you are not legally or contractually responsible to pay.

Balances of $100 or Less

After the required seven-day advance notice, I authorize the practice to charge my card on file for an **undisputed patient-responsibility balance of $100 or less**, unless I contact the practice before the stated charge date to dispute the amount or request that the account be reviewed.

Balances Greater Than $100

For an individual patient-responsibility balance **greater than $100**, the practice will notify me before processing the balance and may contact me to discuss payment arrangements.

When approved by the practice, an outstanding balance may be divided into monthly installments, generally **not exceeding $100 per month**, until the balance is paid in full.

Any approved payment arrangement will be documented with the patient.

The practice may approve a different arrangement when appropriate based upon the patient's individual circumstances, financial hardship, applicable insurance requirements, payer contracts, and applicable law.

Seven-Day Advance Notice

Except for amounts that I specifically authorize for immediate payment - including the initial copayment, other known patient responsibility properly due at the time of service, or the initial 50% self-pay payment described above - the practice will provide at least **seven (7) days' advance notice** before initiating a subsequent card-on-file charge under this authorization.

If I believe a proposed charge is incorrect, I should contact the practice during the notice period so that the account can be reviewed before the scheduled charge is processed.

Patient Financial Responsibility

I understand that insurance verification and benefit information obtained before an appointment may be an estimate and does not necessarily guarantee payment by my insurance company.

I understand that my health plan may ultimately determine my financial responsibility after processing the claim.

I agree to remain responsible for valid amounts determined to be my responsibility under my insurance plan and applicable law.

If I experience financial hardship or believe that a payment arrangement is necessary, I may contact the practice to discuss the available options.

Authorization and Acknowledgment

By signing below, I acknowledge that:

1. I have received and reviewed this Credit Card on File Authorization and Patient Financial Responsibility Agreement.

2. I authorize Call Doctor Packer Telemedicine to maintain my designated payment method through the practice's authorized payment-processing system.

3. I authorize charges consistent with the terms of this agreement and the notices provided to me, subject to my applicable insurance benefits, payer requirements, and applicable law.

4. I understand that maintaining a card on file does not alter my health insurance benefits or require me to pay an amount that I am not legally or contractually responsible to pay.

5. I understand that insurance eligibility and patient-responsibility information obtained before my visit may not represent the insurer's final claim determination.

6. I understand that I will receive at least seven days' advance notice before applicable subsequent card-on-file charges described in this agreement.

7. I understand that I may contact the practice during the notice period if I believe a proposed charge is incorrect.

8. I understand that I may contact the practice regarding billing discrepancies, financial hardship, or available payment arrangements.

9. I understand that replacing, cancelling, or changing my payment card does not eliminate my financial responsibility for valid charges for services already provided.

10. I understand that this authorization does not waive any rights available to me under applicable federal or state law or under my health insurance plan.

Patient Information & Authorization

Please click or tap each field below and type your information. For security, enter only the last four digits of the payment card. Do not enter a full card number, expiration date, or security code on this form.

Patient Name: _____

Date of Birth: _____

Name on Card: _____

Card Type: _____

Last Four Digits of Card Only: _____

Patient/Authorized Representative Signature (type full legal name):

_____

Date: _____

If Signed by Someone Other Than the Patient

Name of Authorized Representative: _____

Relationship to Patient: _____

Authority to Sign on Patient's Behalf: _____

Authorized Representative Signature (type full legal name):

_____

Date: _____

Electronic Signature Notice

Typing a full legal name in a signature field is intended to serve as an electronic signature and acknowledgment of this agreement. The practice may retain the completed electronic form as part of the patient's records.